2022 – 2023

STATE OF MONTANA

Employee Group Benefits Claim Audits

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MEDICAL

LEGISLATIVE AUDIT DIVISION

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June 2024

The Legislative Audit Committee
of the Montana State Legislature:

Enclosed is the report on the claim audit of the state of Montana employee medical and vision benefits plan administered by Allegiance for the calendar year 2022 including run out claims in calendar year 2023 through April 30, 2023. Starting in January 2023, medical claims were administered by Blue Cross and Blue Shield and vision claims were administered by VSP vision, so this is the final audit on Allegiance.

The audit was conducted by Claim Technologies Incorporated, part of Brown & Brown, under a contract between the firm and our office. The comments and recommendations contained in this report represent the views of the firm and not necessarily the Legislative Auditor.

The agency's written response to the report recommendations is included in the back of each report.

Respectfully submitted,

/s/ Angus Maciver

Angus Maciver
Legislative Auditor

23C-09

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Comprehensive Claim Administration Audit

EXECUTIVE SUMMARY REPORT

State of Montana Medical Plans

Administered by Allegiance Benefit Plan Management
Audit Period: January 1, 2022 through April 30, 2023
&
May 1, 2023 through December 31, 2023

Presented to

State of Montana

September 2024

CLAIM TECHNOLOGIES INCORPORATED

PART OF THE BROWN & BROWN TEAM

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INTRODUCTION

This ***Executive Summary*** contains CTI's findings and recommendations from our audit of Allegiance Benefit Plan Management's (Allegiance) administration of the State of Montana (the State) plan managed by the Health Care and Benefits Division within the Montana Department of Administration and subject to the oversight of the State of Montana Legislative Audit Division (the State). The contract between the State and Allegiance ended 12/31/22. The results of the final yearly audit and initial run-out review for the period January 1, 2022 through April 30, 2023 is included in the Specific Findings Report dated December 11, 2023. As a result, the State continued their due diligence in the review of the remaining run-out period through December 31, 2023. Therefore, we have combined the results in this ***Executive Summary.*** You can review the detail that supports CTI's findings and recommendations in our ***Specific Findings Reports*** dated December 11, 2023 & April 30, 2024.

CTI specializes in the audit and control of health plan claim administration. Accordingly, the statements we make relate narrowly and specifically to the overall effectiveness of policies, procedures, and systems Allegiance used to pay the State's claims during the audit period.

CTI conducted the audit according to accepted standards and procedures for claim audits in the health insurance industry. We based our audit findings on the data and documentation provided by the State and Allegiance. The validity of our findings relies on the accuracy and completeness of that information. We planned and performed the audit to gain reasonable assurance that claims were adjudicated consistently and accurately in relationship to the policy provisions and administrative agreement between the State and Allegiance. As required by the State, a draft of this report also was reviewed by Armanino, LLP. While Armanino did not review source documentation, no exceptions to our findings were noted.

While performing the audit, CTI complied with all confidentiality, non-disclosure, and conflict of interest requirements and did not receive anything of value or any benefit of any kind other than agreed upon audit fees.

OBJECTIVES AND SCOPE – JANUARY 1, 2022 – APRIL 30, 2023

The objectives of CTI's audit of Allegiance's claim administration were to determine whether:

- Allegiance followed the terms of its contract with the State;
- Allegiance paid claims according to the provisions of the plan documents and if those provisions were clear and consistent;
- members were eligible and covered by the State's plans at the time a service paid by Allegiance was incurred; and
- any claim administration systems or processes need improvement.

CTI audited Allegiance's claim administration of the the State's medical plans for the period of January 1, 2022 through April 30, 2023. The population of claims and amount paid during that period were:

Total Paid Amount	$163,813,230
Total Number of Claims Paid/Denied/Adjusted	491,518

The audit included the following components which are described in greater detail on the following pages:

- Random Sample Audit of 180 Claims
- 100% Electronic Screening with 30 Targeted Samples
- Operational Review and Questionnaire and Performance Guarantee Validation
- Plan Documentation Analysis

AUDIT FINDINGS AND RECOMMENDATIONS

Random Sample Findings

CTI validated claim processing accuracy based on a sample of 180 medical claims paid or denied by Allegiance during the audit period. We selected the random sample (stratified by the claim billed amount) to provide a statistical confidence level of 95% +/- 3% margin of error.

CTI's Random Sample Audit categorizes errors into key performance indicators. We use this systematic labeling of errors and calculation of performance as the basis for the benchmarks generated using results from our most recent 100 medical claim audits.

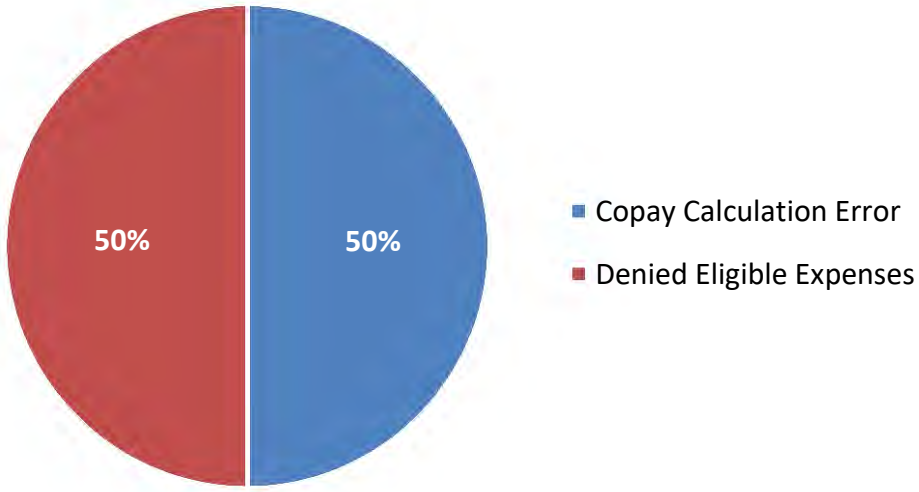
The following table illustrates Allegiance's performance was above the median in all three of CTI's benchmarked performance indicators.

Key Performance Indicators	Administrator's Performance by Quartile				
	Quartile 1	Quartile 2	MEDIAN	Quartile 3	Quartile 4
	Lowest →				*Highest*
Financial Accuracy: Compares total dollars associated with correct claim payments to total dollars of correct claim payments that should have been made.			98.80%		99.89%
Accurate Payment: Compares number of correctly paid claims to total number of claims paid.			96.67%		98.89%
Accurate Processing: Compares number of claims processed without any type of error (financial or non-financial) to total number of claims processed.			97.00%		98.33%

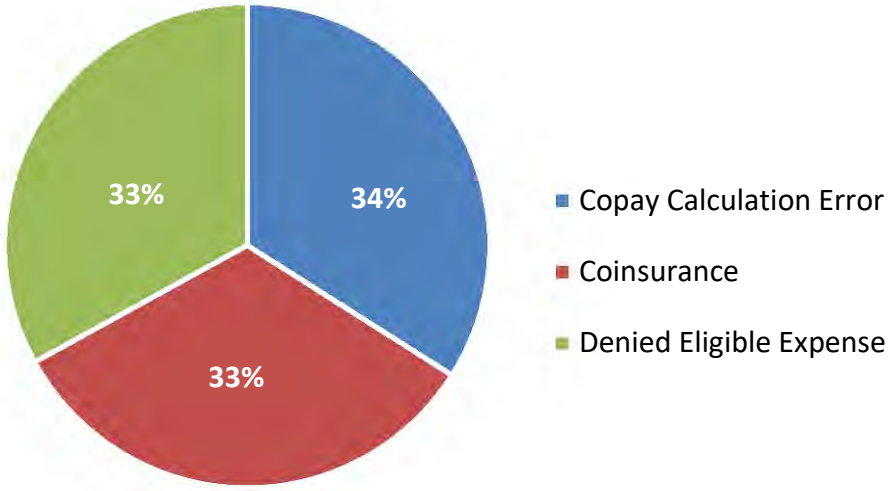
Prioritization of Process Improvement Opportunities

The following chart can help to prioritize improvement and/or recovery opportunities based on savings and service impact and to pinpoint problem causes.

Financial Accuracy Errors



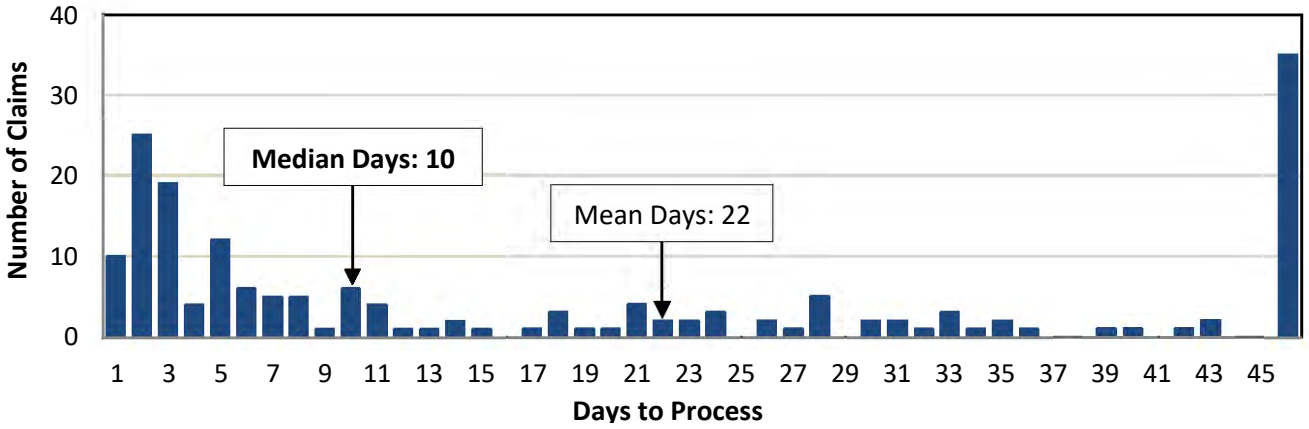
Accurate Processing Errors



Claim Turnaround Time

A final measure of claim administration performance is claim turnaround time. Through the audit sample, Allegiance demonstrated its median turnaround time on a complete claim submission was 10 days from the date it received a complete claim to the date the claim was paid or denied.

Median and Mean Claim Turnaround



Random Sample Recommendation

CTI suggests that the State meet with Allegiance to discuss the audit findings. Allegiance agreed to the two financial errors cited. One error was related to system programming and Allegiance should conduct root cause analysis and identify other potential underpayments. If additional claims are found to have been underpaid, claims should be adjusted to ensure members receive the benefit to which they were entitled. The second financial error was related to a manual error by a claim processor. It, and one additional claim related to the same error, have been corrected. Since this is a "close-out" audit now that the State has terminated its contract with Allegiance, no further action is required.

100% Electronic Screening with Targeted Samples Findings

We used our proprietary Electronic Screening and Analysis System (ESAS) software to further analyze claim payment accuracy as well as any opportunities for system and process improvement. Using the data file provided by Allegiance, we adjudicated each line on every claim the plan paid or denied during the audit period against the plan's benefits. Our Technical Lead Auditor tested a targeted sample of 30 claims to provide insight into Allegiance's claim administration as well as its operational policies and procedures.

The following table shows the medical services identified as potentially overpaid. It is important to note that the amount shown represents potential payment errors; additional testing would be required to substantiate the findings and provide the basis for remedial action planning or recovery.

ESAS Candidates for Additional Testing	Paid/At Risk
Duplicate Payments	$303,635
Excluded Services – Hearing Aids and Supplies	$20,918
Medically Unlikely Edits	$293,701
Preventive Services with Deductible Applied	$34,799

For specific information on the over and underpayments identified, see the ESAS section of CTI's ***Specific Findings Report*** dated December 11, 2023.

100% Electronic Screening with Targeted Samples Recommendations

the State should discuss conducting a focused analysis of the errors identified through ESAS to determine if overpayment recovery can be made. The State and Allegiance should discuss errors where

provider contracts prohibit recovery to determine if other refunds or credits can be made. CTI can prepare claim detail for Allegiance to use in its analysis.

Operational Review Findings

Allegiance completed our Operational Review Questionnaire and provided information on its:

- Systems, staffing, and workflow;
- Claim administration and eligibility maintenance procedures; and
- Internal control risk mechanisms, e.g., HIPAA protections; internal audit policies and practices; and fraud, waste, and abuse detection and prevention.

Our Operational Review indicated:

- Allegiance and the State have a performance agreement with guarantees for the categories of Service and Claim, Implementation, and Provider Access and Stability. Allegiance provided performance reports for 2022 for Claim Quality and Claims Timeliness as well as for Customer Service. In 2022, Allegiance did not achieve the target performance goal for Telephone Response Time, with a result of 1 minute and 26 seconds wait time on a weighted average basis. The goal for this measure is 30 seconds or less. The Call Abandonment Rate of 2% or less also was not met, with 4.82% of calls abandoned before answer. Allegiance issued a check for $48,659.25 on April 13, 2023, as the fee due the State for missing these two performance guarantees. Allegiance measured its performance specifically for the State, a best practice in contrast to administrators who report performance at a service center or book of business level.
- Allegiance provided a copy of the SOC 2 Type 2 System and Organization Controls Report on the Description and Tests of Operating Effectiveness of the Claims Processing System (the Report) for Allegiance Benefit Plan Management for the period July 1, 2021 to June 30, 2022 issued by its external auditor Wipfli LLP. Allegiance's vice president and CFO provided a bridge letter indicating there were no material changes in controls through December 31, 2022. The report was issued in accordance with the requirements of the American Institute of Certified Public Accountants (the AICPA). Wipfli performed various testing procedures against the internal controls identified by Allegiance in the following areas:
    - Control Environment
    - Communication and Information
    - Risk Assessment
    - Monitoring Activities
    - Control Activities
    - Logical and Physical Access Controls
    - System Operations
    - Change Management
    - Risk Mitigation

    No exceptions to Allegiance's controls were noted by Wipfli.

- Allegiance achieved the following overall provider discounts (both network and non-network) during the audit period:

Total of All Claims				
Claim Type	**Allowed Amount**	**Provider Discount**		**Paid**
Ancillary	$7,965,809	$3,426,002	30.1%	$6,904,061
Non-Facility	$63,109,980	$31,384,438	33.2%	$50,846,094
Facility Inpatient	$35,984,172	$11,084,902	23.6%	$33,652,923
Facility Outpatient	$67,589,104	$34,349,651	33.7%	$56,190,876
Total	**$174,649,065**	**$80,244,993**	**31.5%**	**$147,593,954**

Note that discount amounts shown above exclude members 65 and older and include only those claims where the allowed amount is greater than zero.

- Allegiance Provider Network utilization was high at 98.01%. The State's members traveling or domiciled outside of Montana accessed Cigna's OAP network, which helped to drive network savings.
- Allegiance kept an internal log to track appeal timeframes and resolution. Allegiance provided a 2022 summary report. For 2022, there were 109 appeals, 74% of which were upheld. In addition, 92% of appeals were handled timely, although the period for resolution was not specified.
- Allegiance surpassed its contractual performance guarantees of 98% with the State for both Financial Accuracy and Payment Accuracy. Allegiance combined these two measures into one overall category of Financial Payment.
- During the audit period, Allegiance reported it did not have any breaches of member' private information that would trigger notification requirements for the State.

Operational Review Recommendations

Allegiance should amend its performance guarantee report given to the State to report separate results for Financial and Payment Accuracy, rather than combining them.

Plan Documentation Analysis Findings and Recommendations

Our auditors did not identify any inconsistencies, ambiguities, or missing provisions in our Plan Documentation Analysis.

OBJECTIVES AND SCOPE – MAY 1, 2023 – DECEMBER 31, 2023

The objectives of CTI's audit of Allegiance's claim administration were to determine whether:

- Allegiance paid claims according to the provisions of the plan documents and if those provisions were clear and consistent;
- members were eligible and covered by the State's plan at the time a service paid by Allegiance was incurred; and
- any claim administration systems or processes need improvement.

Audit Scope

CTI audited Allegiance's claim administration of the the State's medical plan for the period of January 1, 2022 through April 30, 2023. The population of claims and amount paid during that period were:

Total Paid Amount	$3,002,774
Total Number of Claims Paid/Denied/Adjusted	491,518

100% Electronic Screening with Targeted Samples Findings

We used our proprietary Electronic Screening and Analysis System (ESAS) software to further analyze claim payment accuracy as well as any opportunities for system and process improvement. Using the data file provided by Allegiance, we adjudicated each line on every claim the plan paid or denied during the audit period against the plan's benefits. Our Technical Lead Auditor tested a targeted sample of 30 claims to provide insight into Allegiance's claim administration as well as its operational policies and procedures.

The following table shows the medical services identified as potentially overpaid. It is important to note that the amount shown represents potential payment errors; additional testing would be required to substantiate the findings and provide the basis for remedial action planning or recovery.

ESAS Candidates for Additional Testing	Paid/At Risk
Duplicate Payments	$1,353
Excluded Services – Biofeedback, PA, NP, Nurse surgery assistant & Resident under Physician	$16,352
Medically Unlikely Edits	$4,410
Preventive Services with Copay/Deductible Applied	$731

For specific information on the over and underpayments identified, see the ESAS section of CTI's ***Specific Findings Report*** dated April 30, 2024.

100% Electronic Screening with Targeted Samples Recommendations

the State should discuss conducting a focused analysis of the errors identified through ESAS to determine if overpayment recovery can be made. The State and Allegiance should discuss errors where provider contracts prohibit recovery to determine if other refunds or credits can be made. CTI can prepare claim detail for Allegiance to use in its analysis.

CONCLUSION

We consider it a privilege to have worked for, and with, your staff and administrator. Our contract offers eight hours of post-audit time should the State desire additional assistance.

Thank you again for choosing CTI.

CLAIM TECHNOLOGIES INCORPORATED

PART OF THE BROWN & BROWN TEAM

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Comprehensive Claim Administration Audit

SPECIFIC FINDINGS REPORT

State of Montana Medical Plans

Administered by Allegiance Benefit Plan Management

Audit Period: January 1, 2022 through April 30, 2023

Presented to

Montana Legislative Audit Division

September 2024

CLAIM TECHNOLOGIES INCORPORATED

PART OF THE BROWN & BROWN TEAM

Proprietary and Confidential

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INTRODUCTION

This ***Specific Findings Report*** contains CTI's findings and recommendations from our audit of Allegiance Benefit Plan Management's (Allegiance) administration of the medical plan managed by the Health Care and Benefits Division within the Montana Department of Administration and subject to the oversight of the State of Montana Legislative Audit Division (the State). The statistics, observations, and findings in this report constitute the basis for the analysis and recommendations presented under separate cover in the ***Executive Summary***. We provide this report to the State, the plan sponsor, and Allegiance, the claims administrator. A copy of Allegiance's response to these findings can be found in Appendix B of this report.

CTI specializes in the audit and control of health plan claim administration. Accordingly, the statements we make relate narrowly and specifically to the overall effectiveness of policies, procedures, and systems Allegiance used to pay the State's claims during the audit period.

CTI conducted the audit according to accepted standards and procedures for claim audits in the health insurance industry. We based our audit findings on the data and documentation provided by the State and Allegiance. The validity of our findings relies on the accuracy and completeness of that information. We planned and performed the audit to gain reasonable assurance that claims were adjudicated consistently and accurately in relationship to the policy provisions and administrative agreement between the State and Allegiance. As required by the State, a draft of this report also was reviewed by Armanino, LLP. While Armanino did not review source documentation, no exceptions to our findings were noted.

While performing the audit, CTI complied with all confidentiality, non-disclosure, and conflict of interest requirements and did not receive anything of value or any benefit of any kind other than agreed upon audit fees.

Audit Objectives

The objectives of CTI's audit of Allegiance's claim administration were to determine whether:

- Allegiance followed the terms of its contract with the State;
- Allegiance paid claims according to the provisions of the plan documents and if those provisions were clear and consistent;
- members were eligible and covered by the State's plans at the time a service paid by Allegiance was incurred; and
- any claim administration systems or processes need improvement.

Audit Scope

CTI audited Allegiance's claim administration of the State's medical plans incurred during 2022 and paid through April 30, 2023. The population of claims and amount paid during that period were:

Total Paid Amount	$163,813,230
Total Number of Claims Paid/Denied/Adjusted	491,518

The audit included the following components:

1. **Operational Review and Performance Guarantee Validation**
    - Claim administrator information
    - Claim administrator claim fund account
    - Claim adjudication and eligibility maintenance procedures
    - HIPAA compliance
2. **Plan Documentation Analysis**
    - Plan documents and other approved communications
    - Identify missing provisions, ambiguities, and inconsistencies
    - Administrative services agreement
3. **100% Electronic Screening with 30 Targeted Samples**
    - Systematic analysis of 100% of paid claims
    - Problem identification and quantification
4. **Random Sample Audit of 180 Claims**
    - Statistical confidence at 95% +/- 3%
    - Key Indicator performance levels
    - Benchmarking
    - Identify and prioritize problems

OPERATIONAL REVIEW AND PERFORMANCE GUARANTEE VALIDATION

Objective

CTI's Operational Review evaluates Allegiance's claim administration systems, staffing, and procedures to identify any deficiencies that materially affect its ability to control risk and pay claims accurately on behalf of the plans.

Scope

The scope of the Operational Review included:

- Claim administrator information
  - Financial reporting
  - Claim payment system and coding protocols
  - Data and system security
- Claim funding:
  - Check processing and security
- Claim adjudication and customer service procedures:
  - Exception claim processing
  - Other insurance coverage and adjudication
  - Network utilization
  - Utilization review, case management, and disease management
  - Appeals processing
- HIPAA compliance

Methodology

CTI used an Operational Review Questionnaire to gather information from Allegiance. We modeled our questionnaire after the audit tool used by certified public accounting firms when conducting an SSAE 18 or Systems and Organization Controls (SOC) audit of a service administrator. We modified that tool to elicit information specific to the administration of your plans.

We reviewed Allegiance's responses and any supporting documentation supplied to gain an understanding of the procedures, staffing, and systems used to administer the State's plans. This allowed us to conduct the audit more effectively.

We observed the following:

- Allegiance and the State have a performance agreement with guarantees for the categories of Service and Claim, Implementation, and Provider Access and Stability. Allegiance provided performance reports for 2022 for Claim Quality and Claims Timeliness as well as for Customer Service. In 2022, Allegiance did not achieve the target performance goal for Telephone Response Time, with a result of 1 minute and 26 seconds wait time on a weighted average basis. The goal for this measure is 30 seconds or less. The Call Abandonment Rate of 2% or less also was not met, with 4.82% of calls abandoned before answer. Allegiance issued a check for $48,659.25 on April 13, 2023, as the fee due to the State for missing these two performance guarantees. Allegiance

measured its performance specifically for the State, a best practice in contrast to administrators who report performance at a service center or book of business level.

- Allegiance provided a copy of the SOC 2 Type 2 System and Organization Controls Report on the Description and Tests of Operating Effectiveness of the Claims Processing System (the Report) for Allegiance Benefit Plan Management for the period July 1, 2021 to June 30, 2022 issued by its external auditor Wipfli LLP. Allegiance's vice president and CFO provided a bridge letter indicating there were no material changes in controls through December 31, 2022. The report was issued in accordance with the requirements of the American Institute of Certified Public Accountants (the AICPA). Wipfli performed various testing procedures against the internal controls identified by Allegiance in the following areas:
    - Control Environment
    - Communication and Information
    - Risk Assessment
    - Monitoring Activities
    - Control Activities
    - Logical and Physical Access Controls
    - System Operations
    - Change Management
    - Risk Mitigation

  No exceptions to Allegiance's controls were noted by Wipfli.
- Since 1999, Allegiance has used LuminX claim administration software. Allegiance also contracted with Zelis to detect claim unbundling. Allegiance adopted most NCCI edits, but some were turned off because they were incompatible with provider contracts or because they cause member inconvenience for low-expense items (for example, denial of charges related to drawing blood).
- Allegiance reported it did not subcontract with vendors for any claim processing, member, or provider service functions for the State's account.
- Allegiance achieved the following overall provider discounts (both network and non-network) during the audit period:

Total of All Claims				
Claim Type	**Allowed Amount**	**Provider Discount**		**Paid**
Ancillary	$7,965,809	$3,426,002	30.1%	$6,904,061
Non-Facility	$63,109,980	$31,384,438	33.2%	$50,846,094
Facility Inpatient	$35,984,172	$11,084,902	23.6%	$33,652,923
Facility Outpatient	$67,589,104	$34,349,651	33.7%	$56,190,876
Total	**$174,649,065**	**$80,244,993**	**31.5%**	**$147,593,954**

Note that discount amounts shown above exclude members 65 and older and include only those claims where the allowed amount is greater than zero.

- All Allegiance claim system users maintained unique access passwords. System access and override authority for its employees was based on job description.
- Claims workflow was documented through a flow-chart that includes the paths of processing for both electronic and paper claims. Decision points exist throughout the claims review

process to ensure the inclusion of necessary provider information and other factors that might require pending a claim for review by a claim examiner (for example, accident information, medical records, coordination of benefits information). Claims that included all necessary information were approved for payment without manual review.

- Allegiance had internal procedures to minimize potential overpayments, but when overpayments did occur, an overpayment request was sent. Follow up occurred in 30 days. When overpayments were repaid, the claims were adjusted, and voids and refunds were reflected on the State's check register.
- Allegiance implemented procedures for coverage of telemedicine, COVID-19 vaccines with no cost-sharing, and COVID-19 testing in compliance with the FFCA and CARES acts.
- Allegiance performed Coordination of Benefits (COB) as outlined in the State's summary plan description. It provided a COB savings report for 2022 showing $22,333,722.16 in savings, including savings related to Medicare coordination. These amounts represent 13.7% of paid claims.
- Allegiance provided copies of its internal procedures to demonstrate compliance with Medicare's demand letters to investigate and determine whether Allegiance should be the primary payer for Medicare-eligible persons. Allegiance also provided the CMS Mandatory Reporting procedures to demonstrate its compliance with federal law.
- Allegiance reported 88.22% of claims were submitted electronically; 34.36% auto adjudicated since all required claim elements were present on the claim. This percentage was lower than in prior years, most likely related to the runout period.
- Allegiance identified potential Workers' Compensation claims through ICD-10 codes, provider notes, and member notification. These claims were held until an accident claim form had been completed. There must be at least $1,000 in claim payments before an investigation was undertaken.
- Allegiance's sister company, Allegiance Care Management, performed precertification and large claim management. Written responses to precertification requests were maintained except for oncology services, where a notation of verbal approval was entered into the system. Allegiance reported more than $9 million in savings from Case and Disease Management during 2022.
- Allegiance kept an internal log to track appeal timeframes and resolution. Allegiance provided a 2022 summary report. For 2022, there were 109 appeals, 74% of which were upheld. In addition, 92% of appeals were handled timely, although the period for resolution was not specified.
- Allegiance's claim system did not track the date adjustments were identified; it defaulted to the original claim receipt date. As a result, adjustments were excluded from claim turnaround time calculations and the corresponding performance guarantee.
- Allegiance did not have staff dedicated to detecting and investigating fraud, waste, and abuse. Zelis code editing services provided fraud detection services. If Allegiance identified a case of fraud, it would be turned over to local prosecutors or to the State for further review and action. If any case of fraud was identified with contracted providers, the Allegiance credentialling committee reviewed the information and referred the matter to the State as appropriate.
- Allegiance Provider Network utilization was high at 98.01%. The State's members traveling or domiciled outside of Montana accessed Cigna's OAP network, which helped to drive network savings.

- Allegiance compensated out-of-network providers using a fee schedule based on specialized contract rates that Allegiance administered as part of the State's network. These rates included a Procedure Based Maximum Expenses (PBME) as the maximum amount the Plan would pay. The State's Wrap Document included reference to the PBME as the basis for payment.
- Allegiance adopted procedures to conform with the federal No Surprises Act (NSA). Under the NSA, providers were prohibited from balance billing the member if they were paid the Qualifying Payment Amount (QPA). Determination of the QPA was provided through Cigna for groups using the Maximum Eligible Expense (MEE) Out of Network program. If a member received a balance bill for an NSA-qualifying service, Allegiance informed the member they were not liable for the bill. If the provider pursues the dispute, arbitration or Independent Dispute Resolution (IDR) management was provided for an additional per case fee.
- This cost varied by claim amount and type. This cost varied by claim amount and type. From January 1, 2022 through August 31, 2022 Allegiance used Multiplan for QPA outside of Montana and Cigna QPA within Montana. However, in August 2022, federal regulations were clarified, and Allegiance changed the way the QPA reimbursement was determined in order to comply with federal regulations. At that time, Allegiance began using Procedure Based Maximum Expense (PBME) as the QPA for all applicable claims. Allegiance reported seven member appeals for out-of-network services during 2022. Of the OON services paid at QPA, seven (7) were appealed. Of the OON services paid at QPA, seven (7) were appealed. Of those seven, three (3) were overturned based on the additional documentation submitted and additional allowances were paid. Four (4) of the appeals were upheld and they were submitted to IDR per providers' request. Following the IDR process the QPA was upheld and there was no further allowance paid.

HIPAA Compliance

CTI reviewed information about the systems and processes Allegiance had in place to maintain compliance with HIPAA regulations. The objective was to determine if the administrator was aware of the HIPAA regulations and was compliant at the time of the audit. We offer the following observations from our review:

- Allegiance employees receive online HIPAA training annually and occasionally more often.
- During the audit period, Allegiance reported it did not have any breaches triggering notification requirements for the State.

Performance Guarantee Validation

The Fifth Amendment to the contract between Allegiance and the State included performance guarantees.

The performance guarantee was based on Allegiance's internal random audit policies and procedures and included targets of 98% for Financial Accuracy (defined as an error in claims adjudication that directly affects the amount the State's benefit plan paid for any claim or claim line) and 98% for Payment Accuracy (defined as claims adjudicated for an incorrect amount). Based on CTI's audit, Allegiance surpassed both performance guarantees. Allegiance achieved Financial Accuracy of 99.89%, and 98.89% for Payment Accuracy.

Allegiance's self-reported performance against guarantees was 99.8% for the overall category of Financial Payment, measured by the accuracy of paid benefit dollars. Allegiance did not report separate results for Financial Accuracy and Payment Accuracy.

PLAN DOCUMENTATION ANALYSIS

Objective

CTI's Plan Documentation Analysis evaluates the documents governing administration of the State's medical plans and identifies inconsistencies, ambiguities, or missing provisions that might negatively impact accurate claim administration. Through this evaluation, we gained an understanding of Allegiance's administrative service responsibilities for the State's medical plans. This understanding allowed us to audit more effectively.

Scope

Our auditors evaluated:

- the State's Wrap Plan Document
- Administrative Services Agreement

Methodology

CTI obtained a copy of the plan documentation from the State and/or Allegiance. Our auditors reviewed the applicable documents to better understand the provisions Allegiance should have used to process and pay all medical claims. We used a benefit matrix to help us understand your plan provisions. CTI's benefit matrix is a composite listing of the benefit provisions, exclusions, and limitations we expect to see in a plan document. When completed, the matrix allowed us to identify inconsistencies, ambiguities, or missing provisions.

CTI obtained clarification from the State about any inconsistencies in the plan documents. Our auditors then used the benefit matrix as a cross-reference tool as they audited claims.

Findings

Our auditors did not identify any inconsistencies, ambiguities, or missing provisions in our Plan Documentation Analysis.

100% ELECTRONIC SCREENING WITH TARGETED SAMPLE ANALYSIS

Objective

CTI's Electronic Screening and Analysis System (ESAS®) software identified and quantified potential claim administration payment errors. The State and Allegiance should talk about any verified under- or overpayments to determine the appropriate actions to correct any errors.

Scope

CTI electronically screened 100% of the service lines processed by Allegiance during the audit period. The accuracy and completeness of Allegiance's data directly impacted the screening categories we completed and the integrity of our findings. We screened the plan data for the following high-level ESAS categories to identify potential amounts at risk:

- Duplicate payments to providers and/or employees
- Plan exclusions and limitations
- Multiple surgical procedures
- Copayments, Deductibles, and Out of Pocket
- Coordination of Benefits
- Subrogation/Right of Recovery from Third Party
- Workers' Compensation
- Large Claim Review
- Case Management
- Fraud, Waste, and Abuse
- Preventive Services
- National Correct Coding Initiative and other Editing Compliance

Methodology

We used ESAS to analyze claim payment accuracy as well as any opportunities for system and process improvement. Using the data file provided by Allegiance, we adjudicated each line on every claim the plan paid or denied during the audit period against the plan's benefits. Our Technical Lead Auditor tested a targeted sample of claims to provide insight into Allegiance's claim administration as well as operational policies and procedures. We followed these procedures to complete our ESAS process:

- ***Electronic Screening Parameters*** – We relied on plan document provisions to set ESAS parameters.
- ***Data Conversion*** – We converted and validated the claim data and compared it to the control totals provided by the State to check for reasonableness.
- ***Electronic Screening*** – We systematically adjudicated 100% of the service lines processed and flagged claims not administered according to plan parameters.
- ***Auditor Analysis*** – If claims within an ESAS screening category represented a material amount at risk, our auditors analyzed the findings to confirm results were valid. When using ESAS to identify payment errors, note that incomplete claim data could lead to false positives. CTI auditors made every effort to identify and remove false positives.
- ***Targeted Sample Analysis*** – From the categories identified with material amounts at risk, we selected the best examples of potential under- or overpayments to test. As cases are not randomly selected, we did not extrapolate results. We selected 30 cases and sent Allegiance an

individual questionnaire for each. Targeted samples helped verify if the claim data supported our finding and if Allegiance's administration matched the plan's intent.

- ***Audit of Administrator Response and Documentation*** – We reviewed your response and any additional supporting information provided. Based on this information and any additional analysis required, we removed false positives identified from the potential amounts at risk.

Findings

While we are confident in the accuracy of our ESAS results, note the dollar amounts associated with the results represent potential payment errors and process improvement opportunities. We would have to perform additional testing to substantiate the findings that could then provide the basis for remedial action planning or reimbursement.

The following report shows, by category, the number of line items or claims and the total potential amount at risk remaining at the conclusion of our analysis, targeted samples, and removal of verified false positives. Following the report is a detailed explanation of our results with findings for all screening categories where process improvement, recovery, or savings opportunities exist.

The amounts shown in the Allowed and Paid/At Risk/Potential Recovery column were derived from CTI's compilation and summary of the claim data submitted by Allegiance. The Charge amount represents fees billed by providers prior to application of provider discounts, reduction for excluded or limited services, and modifiers to procedure codes which reduce provider fees. The Paid/At Risk/Potential Recovery amount was determined as follows. As an example, CTI's screening showed $1,253,747 in total claim amounts that may include duplicate payments. CTI considers $303,635, which was the total amount of potential duplicates that may have been applied incorrectly, to be "at risk". Further review is required to verify the Paid/At Risk amount based on the specialty physician types assigned by Allegiance. Similar review is required for all other categories in which errors were identified through our analysis. This additional layer of review will occur following presentation of audit results and further discussion with the State and Allegiance.

It is important to note that even if the sampled claim was subsequently corrected prior to CTI's audit, we have still cited the error so you can discuss how to reduce errors and re-work in the future with your administrator.

Recommended Categories for Additional Testing					
Client: The State of Montana **Screening Period:** January 1, 2022 through April 30, 2023					
Category	**Lines**	**Claimants**	**Charge**	**Allowed**	**Paid/At Risk/ Potential Recovery**
Duplicate Payments					
Providers and/or Employees	1,358	338	$1,253,747	$557,059	$303,635
Plan Exclusions					
Hearing Aids and Supplies	14	9	$35,140	$29,737	$20,918
Medically Unlikely Edits					
Non-Facility	184	98	$458,838	$293,701	$293,701
Preventive Services					
With Deductible Applied	786	541	$63,220	$44,988	$34,799

Electronic screening of all service lines processed revealed the potential for incorrectly paid claims. After review of the response and additional information provided by the administrator, CTI confirmed the potential for process improvement. Further testing is recommended.

ESAS Findings Detail Report				
QID	**Under/ Over Paid**	**Allegiance Response**	**CTI Conclusion**	**Manual or System**
Duplicate Payments				
10	$258.74	Agree. Overpayment request letters sent 7/6/22 and 8/5/22.	Claim was paid twice.	☒ M ☐ S
11	$437.14	Agree. Refund requested for 2022XXXXXXXX on 7/24/23.	Claim was paid twice.	☒ M ☐ S
12	$655.85	Agree. Reversal/void done on 2022XXXXXXXX. Received 7/19/23.	Claim was paid twice. Refund received 7/19/23.	☒ M ☐ S
14	$138.12	Agree. Refund requested for 2023XXXXXXXX on 7/24/23.	Claim was paid twice. Overpayment request letter sent 7/24/23.	☒ M ☐ S
16	$150.00	Agree. Refund requested for 2022XXXXXXXX on 7/24/23.	Claim was paid twice. Overpayment request letter sent 7/24/23.	☒ M ☐ S
18	$2,682.34	Agree. Overpayment letter sent with refund request.	Claim was paid twice. Overpayment request letter sent.	☒ M ☐ S
20	$4,389.77	Agree. Refund requested for 2023XXXXXXXX on 7/24/23. 2023XXXXXXXX is a corrected claim to 2022XXXXXXXX with an increase in charge and allowable amount. Only the additional allowable should have been paid.	Claim was paid twice. Overpayment request letter sent 7/24/23.	☒ M ☐ S
Plan Exclusions				
Category: Hearing Aids and Supplies				
26	$3,585.00	Agree. Hearing aids are limited to dependent children up to age 18. Claim was not eligible for payment and should have been denied as it is related to the Participant at 54 years of age.	Overpayment identified. Hearing aid for an over age 18 member was incorrectly paid.	☒ M ☐ S
Medically Unlikely Edits				
1	$3,249.00	Agree. Due to provider agreement, Allegiance may not seek correction of a payment more than 12 months after it was made.	Units for ABA therapy were incorrectly applied. Claim was overpaid.	☒ M ☐ S
Preventive Services				
With Deductible Applied				
3	$1,005.54	Agree. Both charges should have allowed at 100% as preventive. Claim has been submitted for history and void correction.	Underpayment identified. Claim to be adjusted to issue correct benefits.	☒ M ☐ S

RANDOM SAMPLE AUDIT

Objectives

The objectives of our Random Sample Audit were to determine if claims were paid according to plan specifications and the administrative agreement, to measure and benchmark process quality, and to prioritize areas of administrative deficiency for further review and remediation.

Scope

CTI's Random Sample Audit included a stratified random sample of 180 paid or denied claims. The statistical confidence level of the audit sample was 95%, with a 3% margin of error. A copy of the Sample Construction and Weighting Methodology Report for the sample is in Appendix A. Allegiance's performance was measured using the following key performance indicators:

- Financial Accuracy;
- Accurate Payment; and
- Accurate Processing.

We also measured claim turnaround time, a commonly relied upon performance measure.

Methodology

Our Random Sample Audit ensures a high degree of consistency and is based upon the principles of statistical process control with a management philosophy of continuous quality improvement. Our auditors reviewed each sample claim selected to ensure it conformed to plan specifications, agreements, and negotiated discounts. We recorded our findings in our proprietary audit system.

When applicable, we cited claim payment and processing errors identified by comparing the way a selected claim was paid and the information Allegiance had available at the time the transaction was processed**. It is important to note that even if the sampled claim was subsequently corrected prior to CTI's audit, we have still cited the error so you can discuss how to reduce errors and re-work in the future with your administrator.**

CTI communicated with Allegiance in writing via system-generated response forms regarding any errors or observations. We sent Allegiance a preliminary report for its review and written response. We considered Allegiance's written response, as found in Appendix B, when producing our final reports.

Findings

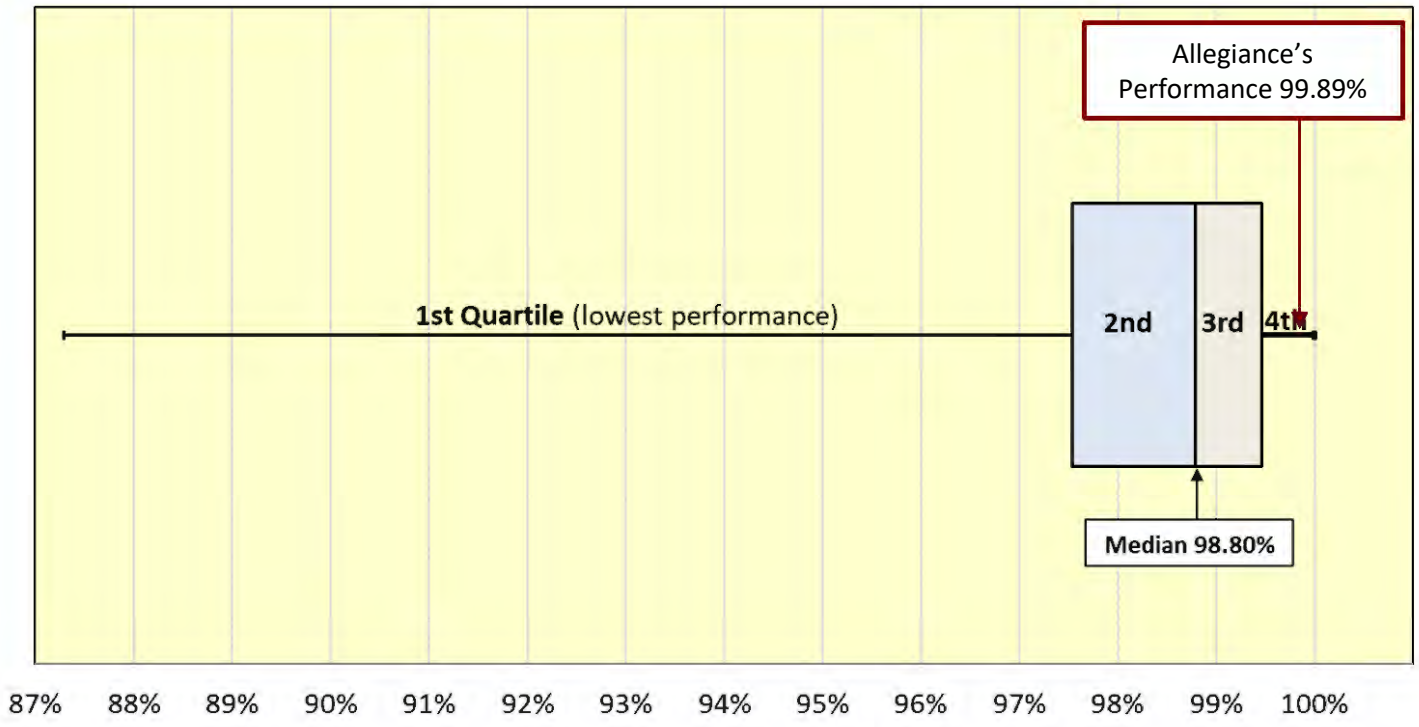
The following box and whiskers charts demonstrate Allegiance's performance as compared to the last 100 medical audits performed by CTI. The fourth quartile represents the 25 highest performing plans, and the first quartile represents the lowest 25. The Median is the point at which 50 plans audited were above, and 50 plans were below.

Financial Accuracy

CTI defines Financial Accuracy as the total correct claim payments made compared to the total dollars of correct claim payments that should have been made for the audit sample.

The claims sampled and reviewed revealed $33.00 in underpayments and no overpayments, for a combined variance of $33.00. The correct payment total for the adequately documented claims in the audit sample should have been $711,199.32.

The weighted Financial Accuracy rate was 99.89%.



Accurate Payment Frequency

CTI defines Accurate Payment Frequency as the number of claims paid correctly compared to the total number of claims paid for the audit sample.

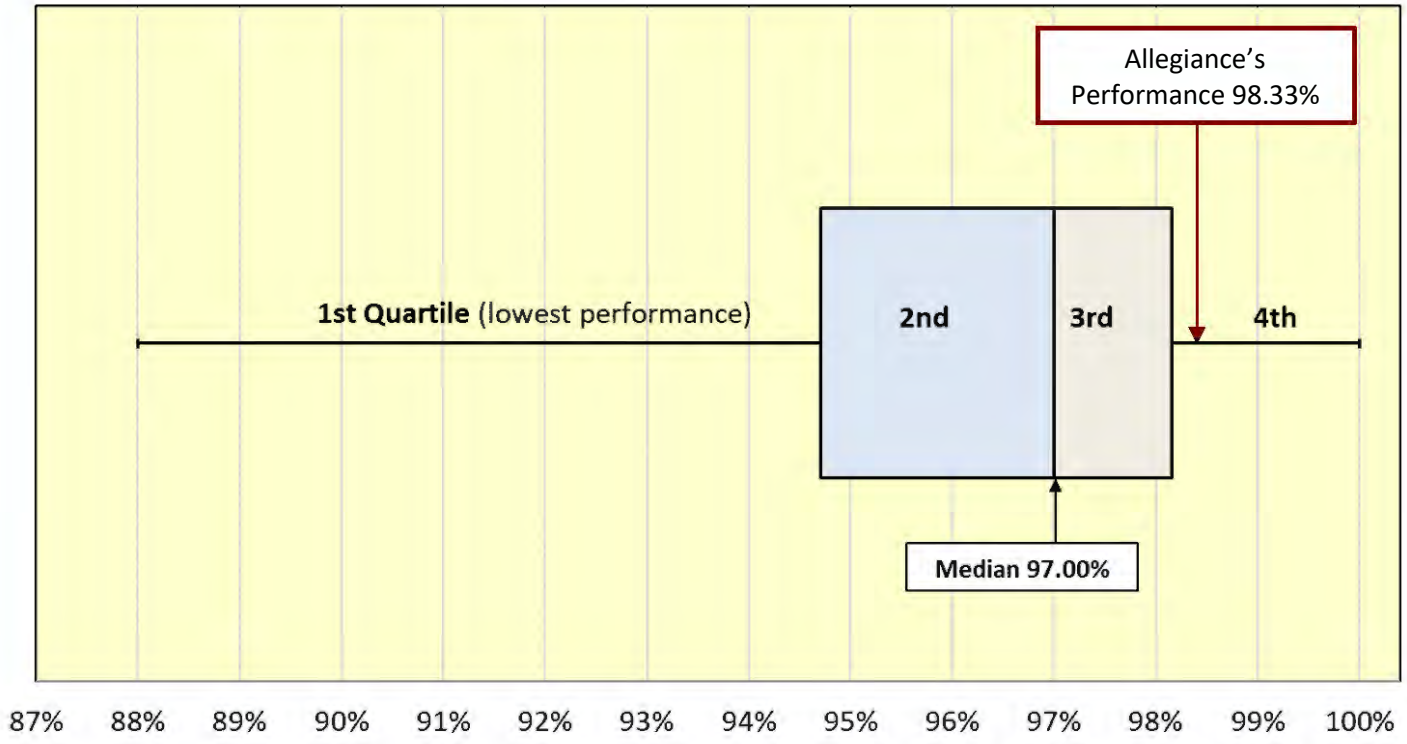
The audit sample revealed 2 incorrectly paid claims and 178 correctly paid claims. Note CTI only uses adequately documented claims for this calculation.

Total Claims	Incorrectly Paid Claims		Frequency
	Underpaid	Overpaid	
180	2	0	98.89%

Accurate Processing Frequency

CTI defines Accurate Processing Frequency as the number of claims processed without errors compared to the total number of claims processed in the audit sample. When a claim had errors that applied in more than one category, it was counted only once as a single incorrect claim for this measure.

Correctly Processed Claims	Incorrectly Processed Claims		Frequency
	System	Manual	
177	2	1	98.33%



Random Sample Findings Detail Report				
Audit No.	**Under/ Over Paid**	**Allegiance Response**	**CTI Conclusion**	**Manual or System**
Copay Calculation Error				
1159	$0.00	Disagree. The out-of-pocket (OOP) is not over accumulated. Due to the order in which claims were processed, the OOP was met on 2023XXXXXXXX.	CTI will continue to cite a procedural error. Based on the "SOM audit claims for DED and OOP" document provided by Allegiance, the member had only satisfied $3,950.00 of the $4,000.00 OOP at the time the claim processed on 12/30/22. The member's $4,000.00 2022 OOP was satisfied on a claim that was subsequently processed by Allegiance on 1/24/23.	☐ M ☒ S
Coinsurance Error				
1156	$10.00	Agree. The general specialist office visit co-pay was applied of $35. All indicators point to Allergy benefits, i.e., the specialist code, location and diagnosis.	Underpayment and procedural error remain. Copay should have been $25.00 rather than $35.00 for allergy treatment office visit as stated on page 3 of the Wrap Document.	☐ M ☒ S
Denied Eligible Expense				
1148	$23.00	Agree. Dietary and Nutritional counsel has a 3 visit limitation. Only one other nutritional counseling claim was received.	Underpayment and procedural error remain. Eligible expenses for obesity (dietary and nutritional counseling) were denied in error.	☒ M ☐ S

Claim Turnaround

CTI defines Claim Turnaround as the number of calendar days required to process a claim – from the date the claim was received by the administrator to the date a payment, denial, or additional information request was processed – expressed as both the Median and Mean for the audit sample.

Claim administrators commonly measure claim turnaround time in mean days. Median days, however, is a more meaningful measure for administrators to focus on when analyzing claim turnaround because it prevents one or just a few claims with extended turnaround time from distorting the true performance picture.

Median	Mean	+45 Days to Process
10	22	35

CONCLUSION

We consider it a privilege to have worked for, and with, your staff and administrator. Our contract offers eight hours of post-audit time should the State desire additional assistance.

Thank you again for choosing CTI.

APPENDIX A – SAMPLE CONSTRUCTION AND WEIGHTING METHODOLOGY

Client: MT Allegiance Closeout 23
Audit Period: January 01, 2022 - April 30, 2023

Claim Universe (as converted)

Stratum		Claim Count	Total Charge Amount	Total Paid Amount
<=500	1	402,815	$67,937,173	$31,665,003
<=10,000	2	81,553	$140,978,385	$49,645,597
>10,000	3	7,150	$236,012,098	$82,502,630
Totals		491,518	$444,927,655	$163,813,230

Audit Stratification

Stratum		Audit Universe (# Claims)	Proportion (Weight by Count)	Sample
<=500	1	402,815	81.95%	60
<=10,000	2	81,553	16.59%	60
>10,000	3	7,150	1.45%	60
Totals		491,518	100.00%	180

Audit Sample Overview

Category	Count	Paid Amount
Claims requested for audit	180	$711,166.32
Claims for which records not received	0	$0.00
Claims outside scope of audit	0	$0.00
Claims as entered included in audit sample	180	$711,166.32
Audit sample if all claims paid correctly	180	$711,199.32
Claims with inadequate documentation	0	$0.00
Total claim payments remaining in audit sample	180	$711,199.32

APPENDIX B – ADMINISTRATOR RESPONSE TO DRAFT REPORT

Please note that any additional information submitted to CTI in response to the draft report from the administrator is reviewed, and observations may be removed prior to the final report being published. While a removed observation will not be included in the final report, it may be referenced in the administrator's response that follows.

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ALLEGIANCE BENEFIT PLAN MANAGEMENT'S RESPONSE TO CTI AUDIT RESULTS FOR THE STATE OF MONTANA EMPLOYEE HEALTH BENEFIT PLAN FOR PERIOD JANUARY 1, 2021 THROUGH DECEMBER 31, 2022

Allegiance Benefit Plan Management, Inc. (Allegiance) has reviewed the results issued by CTI of its performance audit for the period from January 1, 2021 through December 31, 2022 of the State of Montana Employee Health Benefit Plan for which Allegiance provides third party administrator services. Based upon that review, Allegiance in large part agrees with the audit findings which confirm the superior quality of services provided by Allegiance.

However, Allegiance identified one finding to which Allegiance disagrees. On page 6 there is a reference to NCCI coding edits in part being turned off. This has been discussed in prior audits. Coding edits are turned on for professional claims through an editing service company called Zelis and for institutional claims through the reference based pricing performed by Payer Compass. As we have discussed, code editing is very complex with hundreds of thousands of coding rules from the National Comprehensive Coding Initiative (Medicare), the CPT and HCPCS coding manuals, and various Association rules and recommendations. The reason that an edit may not always trigger is that there is a significant difference between the existence of an edit and the processing of an edit such that quite often the edit is allowed to be bypassed in the coding rules. One such situation is through the use of modifiers. Use of modifier 25 (Significant, Separately Identifiable Evaluation and Management Service by the same Physician), 57 (Decision for Surgery), or 59 (Distinct Procedural Service) will all allow edits to be bypassed in certain situations. There are also many more such modifiers and other qualifiers that allow edits to be bypassed even when they are turned on. In addition some specific edits have been customized to be turned off. For example, the edit which denies the charge for drawing blood has been turned off because the minimal charge, and especially the minimal payment after PPO discount, is not a risk to the Plan and is a good investment when compared to the displeasure and discontent it causes the members, HR and providers. In summary, just because an edit exists does not mean it will always apply per the rules or that it always makes sense to apply it.

Thank you for the opportunity to work with CTI. Their auditor was very professional and courteous to the Allegiance staff during the audit .

DocuSigned by:
Kim Browne
4CF6F04173A14EB...

Kimberly A. McGuire-Browne
Senior Vice-President
Allegiance Benefit Plan Management, Inc.

From: Kim Browne <Kim.Browne@AskAllegiance.com>
Sent: Monday, November 20, 2023 6:05 PM
To: Daniel Montgomery <dmontgomery@claimtechnologies.com>; Amber Ireland <Amber.Ireland@askallegiance.com>; Sheri L. Casas <Sheri.Casas@AskAllegiance.com>
Cc: Jenks, Amy <AJenks@mt.gov>
Subject: [External] RE: Report Language

[External]

Dan

After reviewing internally I believe that this is the outcome based on the response we provided.

KB

Of the OON services paid at QPA, seven (7) were appealed. Of those seven, three (3) were over turned based on the additional documentation submitted and additional allowances were paid. Four (4) of the appeals were upheld and they were submitted to IDR per providers request. Following the IDR process the QPA was upheld and there was no further allowance paid.

Kim Browne
Allegiance Benefit Plan Management

CLAIM TECHNOLOGIES INCORPORATED

PART OF THE BROWN & BROWN TEAM

100 Court Avenue – Suite 306 • Des Moines, IA 50309
(515) 244-7322 • claimtechnologies.com

Claim Administration Audit

SPECIFIC FINDINGS REPORT

State of Montana Medical Plan

Administered by Allegiance Benefit Plan Management

Audit Period: May 1, 2023 through December 31, 2023

Presented to

State of Montana

September 2024

CLAIM TECHNOLOGIES INCORPORATED

PART OF THE BROWN & BROWN TEAM

Proprietary and Confidential

TABLE OF CONTENTS

INTRODUCTION

This ***Specific Findings Report*** contains CTI's findings and recommendations from our audit of Allegiance Benefit Plan Management's (Allegiance) administration of the medical plan managed by the Health Care and Benefits Division within the Montana Department of Administration and subject to the oversight of the State of Montana Legislative Audit Division (the State). The statistics, observations, and findings in this report constitute the basis for the analysis and recommendations presented under separate cover in the ***Executive Summary*** dated April 30, 2024. The contract between the State and Allegiance ended 12/31/22. The results of the final yearly audit and initial run-out review for the period January 1, 2022 through April 30, 2023 is included in the Specific Findings Report dated December 11, 2023. As a result, the State continued their due diligence in the review of the remaining run-out period through December 31, 2023. Therefore, we have combined the results in the ***Executive Summary***. We provide this report to the State, the plan sponsor, and Allegiance, the claims administrator. A copy of Allegiance's response to these findings can be found in the Appendix of this report.

CTI conducted the audit according to accepted standards and procedures for claim audits in the health insurance industry. We based our audit findings on the data and information provided by the State and Allegiance. The validity of our findings relies on the accuracy and completeness of that information. We planned and performed the audit to gain reasonable assurance that claims were adjudicated consistently and accurately in relationship to the policy provisions and administrative agreement between the State and Allegiance.

CTI specializes in the audit and control of health plan claim administration. Accordingly, the statements we make relate narrowly and specifically to the overall effectiveness of policies, procedures, and systems Allegiance used to pay the State's claims during the audit period. While performing the audit, CTI complied with all confidentiality, non-disclosure, and conflict of interest requirements and did not receive anything of value or any benefit of any kind other than agreed upon audit fees.

Audit Objectives

The objectives of CTI's audit of Allegiance's claim administration were to determine whether:

- Allegiance followed the terms of its contract with the State;
- Allegiance paid claims according to the provisions of the plan documents and if those provisions were clear and consistent;
- members were eligible and covered by the State's plan at the time a service paid by Allegiance was incurred; and
- any claim administration systems or processes need improvement.

Audit Scope

CTI audited Allegiance's claim administration of the the State's medical plan for the period of May 1, 2023 through December 31, 2023. The population of claims and amount paid during that period were:

Total Paid Amount	$3,002,774
Total Number of Claims Paid/Denied/Adjusted	17,037

The audit included the following components:

- **100% Electronic Screening with 75 Targeted Samples**
  - Systematic analysis of 100% of paid claims
  - Problem identification and quantification

100% ELECTRONIC SCREENING WITH TARGETED SAMPLE ANALYSIS

Objective

CTI's Electronic Screening and Analysis System (ESAS®) software identified and quantified potential claim administration payment errors. The State and Allegiance should talk about any verified under- or overpayments to determine the appropriate actions to correct any errors.

Scope

CTI electronically screened 100% of the service lines processed by Allegiance during the audit period. The accuracy and completeness of Allegiance's data directly impacted the screening categories we completed and the integrity of our findings. We screened the plan data for the following high-level ESAS categories to identify potential amounts at risk:

- Duplicate payments to providers and/or employees
- Plan exclusions and limitations
- Multiple surgical procedures
- Copayments, Deductibles, and Out of Pocket
- Coordination of Benefits
- Subrogation/Right of Recovery from Third Party
- Workers' Compensation
- Large Claim Review
- Case Management
- Fraud, Waste, and Abuse
- Preventive Services
- National Correct Coding Initiative and other Editing Compliance

Methodology

We used ESAS to analyze claim payment accuracy as well as any opportunities for system and process improvement. Using the data file provided by Allegiance, we adjudicated each line on every claim the plan paid or denied during the audit period against the plan's benefits. Our Technical Lead Auditor tested a targeted sample of claims to provide insight into Allegiance's claim administration as well as operational policies and procedures. We followed these procedures to complete our ESAS process:

- ***Electronic Screening Parameters*** – We relied on the plan document provisions to set the parameters in ESAS.
- ***Data Conversion*** – We converted and validated the claim data and compared it to the control totals provided by the State to check for reasonableness.
- ***Electronic Screening*** – We systematically adjudicated 100% of the service lines processed and flagged claims not administered according to plan parameters.
- ***Auditor Analysis*** – If claims within an ESAS screening category represented a material amount at risk, our auditors analyzed the findings to confirm results were valid. When using ESAS to

identify payment errors, note that incomplete claim data could lead to false positives. CTI auditors made every effort to identify and remove false positives.

- ***Targeted Sample Analysis*** – From the categories identified with material amounts at risk, we selected the best examples of potential under- or overpayments to test. As cases were not randomly selected, we did not extrapolate results. We selected up to 75 cases and sent Allegiance an individual questionnaire for each. Targeted samples helped verify if the claim data supported our finding and if Allegiance's administration matched the plan's intent.
- ***Audit of Administrator Response and Documentation*** – We reviewed Allegiance's response and any additional supporting information provided. Based on this information and any additional analysis required, if false positives were identified, we removed the identified claims from the potential amounts at risk.

Findings

While we are confident in the accuracy of our ESAS results, note the dollar amounts associated with the results represent potential payment errors and process improvement opportunities. We would have to perform additional testing to substantiate the findings that could then provide the basis for remedial action planning or reimbursement.

The following report shows, by category, the number of line items or claims and the total potential amount at risk remaining at the conclusion of our analysis, targeted samples, and removal of verified false positives. Following the report is a detailed explanation of our results with findings for all screening categories where process improvement, recovery or savings opportunities exist. The administrator responses are copied directly from Allegiance's reply to the audit findings.

The amounts shown in the Allowed and Paid/At Risk/Potential Recovery column were derived from CTI's compilation and summary of the claim data submitted by Allegiance. The Charge amount represents fees billed by providers prior to application of provider discounts, reduction for excluded or limited services, and modifiers to procedure codes which reduce provider fees. The Paid/At Risk/Potential Recovery amount was determined as follows. As an example, CTI's screening showed $14,387 in total claim amounts that may include claims from plan exclusions – PA, Nurse Practitioners, Surgery Asst. CTI considers $14,837, which was the total amount of payments that were paid in contrast with the plan document, to be "at risk". Further review is required to verify the Paid/At Risk amount based on the specialty physician types assigned by Allegiance. Similar review is required for all other categories in which errors were identified through our analysis. This additional layer of review will occur following presentation of audit results and further discussion with the State and Allegiance.

It is important to note that even if the sampled claim was subsequently corrected prior to CTI's audit, we have still cited the error so you can discuss how to reduce errors and re-work in the future with your administrator.

Recommended Operational ESAS Categories for Additional Testing				
Client: The State of Montana **Screening Period:** May 1, 2023 through December 31, 2023				
Category	**Lines**	**Claimants**	**Allowed**	**At Risk**
PPO Provider without Discount*				$0*
Medically Unlikely Edits				
Non-Facility	27	11	$4,410	$4,410
Preventive Services				
With Copay Applied	3	3	$3,646	$75
With Deductible Applied	5	4	$656	$656
Duplicate Payments				
Providers and/or Employees	30	6	$1,532	$1,353
Plan Exclusions				
PA, Nurse Practitioners, Nurse Surgery Asst.	125	43	$14,837	$14,837
Resident Under Physician Direction	29	15	$1,570	$1,441
Biofeedback	2	2	$124	$74

**Allegiance reviewed all other PPO Provider without Discount findings and there were no additional errors.*

Electronic screening of all service lines processed revealed the potential for incorrectly paid claims. After review of the response and additional information provided by the administrator, CTI confirmed the potential for process improvement. Further testing is recommended.

ESAS Findings Detail Report				
QID	**Under/ Over Paid**	**Allegiance Response**	**CTI Conclusion**	**Manual or System**
Medically Unlikely Edits – Non-Facility				
3	$25.00	**Original Response:** Policy attached separately. The copy of the claim bill is attached separately. An edit was applied to this claim by Zelis but it was overridden by the examiner. This is an error – however, we are past runout for this group.	A procedural deficiency and $25.00 overpayment identified. Allegiance indicates they will not be recovering the overpayment as the group is past its runout period.	☒ M ☐ S
Preventive Services				
Copay Applied				
5	($25.00)	**Original Response:** Claim [redacted] is not related to preventive care services. The CPT and diagnosis codes billed are all for maternity services rendered at POS 11 (Office). In compliance with the plan document, a $25 copayment was applied. Screenprints of the CPT and diagnosis code descriptions are attached separately, along with State of Montana's plan document highlighting Pregnancy/ Maternity benefits.	A procedural deficiency and $25.00 underpayment identified. Antpartum care should be paid with no costshare applied as this would fall under the Women's Preventive Care, item 3. A. per page 21 of the SPD/Appendix A (Medical) - Effective 1/1/2022: "Well-women annual visits for women 18 years of age and older to obtain the recommended preventive services that are age and developmentally appropriate, including preconception and prenatal care, and additional visits as medically appropriate."	☒ M ☐ S

ESAS Findings Detail Report				
QID	**Under/ Over Paid**	**Allegiance Response**	**CTI Conclusion**	**Manual or System**
Deductible Applied				
10	($165.75)	**Original Response:** The system can only review the REV code on UB claims, not the specific CPT code. This claim did apply to deductible in error however, we are past runout for this group.	A procedural deficiency and $165.75 underpayment identified. Allegiance indicates they will not be issuing the underpayment as the group is past its runout period.	☒ M ☐ S
15	($400.86)	**Original Response:** The system can only review the REV code on UB claims, not the specific CPT code. This claim did apply to deductible in error however it is past runout period for the group.	A procedural deficiency and $400.86 underpayment identified. Allegiance indicates they will not be issuing the underpayment as the group is past its runout period.	☒ M ☐ S
PPO Provider Without Discount				
Anesthesia				
26	$470.00	**Original Response:** The Anesthesia units were not indexed correctly. The true allowed amount is $650. Please see pricing methodology attached.	A procedural deficiency and $470.00 Overpayment identified. Allegiance indicates anesthesia units were not indexed correctly. The true allowed amount is $650.	☒ M ☐ S
Duplicate Payments				
38	$15.88	**Original Response:** Agree. Claim [redacted] is a duplicate. Payment was less than $50. Per policy, refund is not requested and run-out period has ended.	A procedural deficiency and $15.88 overpayment identified. Allegiance indicates refund is not requested and run-out period has ended.	☒ M ☐ S
39	$12.75	**Original Response:** Agree. [redacted] is duplicate to [redacted] Payment was less than $50. Per policy, refund is not requested and run-out period has ended.	A procedural deficiency and $12.75 overpayment identified. Allegiance indicates refund is not requested and run-out period has ended.	☒ M ☐ S
Exclusions				
PA, Nurse Practitioner, Nurse Surgery Assistant				
62	$5,544.45	**Original Response:** Per Codelink CMS Modifier 'AS' should not have been allowed.	A procedural deficiency and $5,544.45 overpayment identified. Allegiance indicates AS should not have been allowed. The plan paid the surgeon and co-surgeon charges.	☒ M ☐ S
Resident Under Physician Direction				
65	$478.00	**Original Response:** Agree. The claim should be denied due to exclusion. No supporting documentation available.	A procedural deficiency and $478.00 overpayment identified. Allegiance indicates residents should not be allowed under the plan language.	☒ M ☐ S
66	$267.52	**Original Response:** Agree. The claim should be denied due to exclusion. No supporting documentation available.	A procedural deficiency and $267.52 overpayment identified. Allegiance indicates residents should not be allowed under the plan language.	☒ M ☐ S

ESAS Findings Detail Report				
QID	**Under/ Over Paid**	**Allegiance Response**	**CTI Conclusion**	**Manual or System**
67	$175.00	**Original Response:** Agree. The claim should have denied. There is no documentation available to support processing.	A procedural deficiency and $175.00 overpayment identified. Allegiance indicates residents should not be allowed under the plan language.	☐ M ☒ S
Biofeedback				
68	$37.04	**Original Response:** Agree. Line 3 90875 should have been denied due to plan exclusion.	A procedural deficiency and $37.04 overpayment identified. Allegiance indicates biofeedback should be denied according to policy language.	☒ M ☐ S
69	$37.04	**Original Response:** Agree. Line 3 90875 should have been denied due to plan exclusion.	A procedural deficiency and $37.04 overpayment identified. Allegiance indicates biofeedback should be denied according to policy language.	☒ M ☐ S

Additional Observation

During the ESAS review, our auditor observed the following procedures or situations that may not have caused an error on the sampled claim but may impact future claims or overall quality of service.

Observation	QID Number
CTI's Finding: Services rendered in a facility and billed on a UB Form should have been issued to the facility. **Allegiance Original Response:** Box 53, Assigned Benefits, on the UB is marked yes. Payment should have been issued to the facility.	46

RECOMMENDATION

Based on our findings, we recommend the State and Allegiance discuss remediation measures, to reimburse the State for the financial errors cited in this report.

CONCLUSION

We consider it a privilege to have worked for, and with, your staff and administrator. Our contract offers eight hours of post-audit time to assist with recovery activity should the State desire additional assistance in that regard.

Thank you again for choosing CTI.

APPENDIX – ADMINISTRATOR RESPONSE TO DRAFT REPORT

Please note that any additional information submitted to CTI in response to the draft report from the administrator is reviewed, and observations may be removed prior to the final report being published. While a removed observation will not be included in the final report, it may be referenced in the administrator's response that follows.

ALLEGIANCE BENEFIT PLAN MANAGEMENT'S RESPONSE TO CTI AUDIT RESULTS FOR THE STATE OF MONTANA EMPLOYEE HEALTH BENEFIT PLAN FOR PERIOD 05/01/2023 – 12/31/2023

Allegiance Benefit Plan Management, Inc. (Allegiance) has reviewed the results issued by CTI of its performance audit for the period from 05/01/2023 through 12/31/2023 of the State of Montana Employee Health Benefit Plan for which Allegiance provides third party administrator services. Based upon that review, Allegiance in large part agrees with the audit findings which confirm the superior quality of services provided by Allegiance. However, Allegiance has identified the following findings to which Allegiance disagrees.

On page 6 the category for Medically Unlikely Edits, This has been discussed in prior audits:

Coding edits are turned on for professional claims through an editing service company called Zelis and for institutional claims through the reference-based pricing performed by Payer Compass. As we have discussed, code editing is very complex with hundreds of thousands of coding rules from the National Comprehensive Coding Initiative (Medicare), the CPT and HCPCS coding manuals, and various Association rules and recommendations. The reason that an edit may not always trigger is that there is a significant difference between the existence of an edit and the processing of an edit such that quite often the edit is allowed to be bypassed in the coding rules. One such situation is through the use of modifiers. Use of modifier 25 (Significant, Separately Identifiable Evaluation and Management Service by the same Physician), 57 (Decision for Surgery), or 59 (Distinct Procedural Service) will all allow edits to be bypassed in certain situations. There are also many more such modifiers and other qualifiers that allow edits to be bypassed even when they are turned on. In addition, some specific edits have been customized to be turned off. For example, the edit which denies the charge for drawing blood has been turned off because the minimal charge.

DocuSigned by:
Kim Browne
4CF6F04173A14EB...

Kimberly A. McGuire-Browne
Senior Vice-President
Allegiance Benefit Plan Management, Inc.

CLAIM TECHNOLOGIES INCORPORATED

PART OF THE BROWN & BROWN TEAM

100 Court Avenue – Suite 306 • Des Moines, IA 50309
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LEGISLATIVE AUDIT DIVISION

Angus Maciver, Legislative Auditor
Kenneth E. Varns, Legal Counsel

Deputy Legislative Auditors:
Cindy Jorgenson
William Soller
Miki Cestnik

June 2024

The Legislative Audit Committee
of the Montana State Legislature:

Enclosed is the report on the claim audit of the state of Montana employee medical benefits plan administered by Blue Cross and Blue Shield for the calendar year 2023.

The audit was conducted by Claim Technologies Incorporated, part of Brown & Brown, under a contract between the firm and our office. The comments and recommendations contained in this report represent the views of the firm and not necessarily the Legislative Auditor.

The agency's written response to the report recommendations is included in the back of each report.

Respectfully submitted,

/s/ Angus Maciver

Angus Maciver
Legislative Auditor

23C-09

Room 160 · State Capitol Building · P.O. Box 201705 · Helena, MT · 59620-1705
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https://leg.mt.gov/lad

Post Implementation Claim Administration Audit

SPECIFIC FINDINGS REPORT

State of Montana Medical Plan

Administered by Blue Cross Blue Shield of Montana

Audit Period: January 1, 2023 through March 31, 2023

Presented to

State of Montana

September 2024

CLAIM TECHNOLOGIES INCORPORATED

PART OF THE BROWN & BROWN TEAM

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INTRODUCTION

This Specific Findings Report contains CTI's findings and recommendations from our audit of BlueCross Blue Shield of Montana's (BCBSMT) administration of the medical plan managed by the Health Care and Benefits Division within the Montana Department of Administration and subject to the oversight of the State of Montana Legislative Audit Division (the State). The observations, and findings in this report constitute the basis for the analysis and recommendations presented. We provide this report to the State, the plan sponsor, and BCBSMT, the claims administrator. BCBSMT responded to each of the audit findings within the body of this report.

CTI conducted the audit according to accepted standards and procedures for claim audits in the health insurance industry. We based our audit findings on the data and information provided by the State and BCBSMT. The validity of our findings relies on the accuracy and completeness of that information. We planned and performed the audit to obtain reasonable assurance claims were adjudicated according to the terms of the contract between BCBSMT and the State.

CTI specializes in the audit and control of health plan claim administration. Accordingly, the statements we make relate narrowly and specifically to the overall effectiveness of policies, procedures, and systems BCBSMT used to pay the State's claims during the audit period. While performing the audit, CTI complied with all confidentiality, non-disclosure, and conflict of interest requirements and did not receive anything of value or any benefit of any kind other than agreed upon audit fees.

Audit Objectives

The objectives of CTI's audit of BCBSMT's claim administration were to determine whether:

- BCBSMT followed the terms of its contract with The State;
- BCBSMT paid claims according to the provisions of the plan documents and if those provisions were clear and consistent;
- members were eligible and covered by The State's plan at the time a service paid by BCBSMT was incurred; and
- any claim administration systems or processes need improvement.

Audit Scope

CTI audited BCBSMT's claim administration of the State medical plan for the period of January 1, 2023 through March 31, 2023. The population of claims and amount paid during that period were:

Total Paid Amount	$22,270,702
Total Number of Claims Paid/Denied/Adjusted	67,375

The audit included the following components:

1. **Plan Documentation Analysis**
   - Plan documents and other approved communications
   - Identify missing provisions, ambiguities, and inconsistencies
2. **100% Electronic Screening with 75 Targeted Samples**
   - Systematic analysis of 100% of paid claims
   - Problem identification and quantification

PLAN DOCUMENTATION ANALYSIS

Objective

CTI's Plan Documentation Analysis evaluates the documents governing administration of The State's medical plan and identifies inconsistencies, ambiguities, or missing provisions that might negatively impact accurate claim administration. Through this evaluation, we gained an understanding of BCBSMT's administrative service responsibilities for The State's medical plan. This understanding allowed us to audit more effectively.

Scope

Our auditors evaluated plan documents, descriptions, and any amendments provided by the State.

Methodology

CTI obtained a copy of the plan documentation from The State and/or BCBSMT. Our auditors reviewed the applicable documents to better understand the provisions BCBSMT should have used to process and pay all medical claims. We used a benefit matrix to help us understand your plan provisions. CTI's benefit matrix is a composite listing of the benefit provisions, exclusions, and limitations we expect to see in a plan document. When completed, the matrix allowed us to identify inconsistencies, ambiguities, or missing provisions.

CTI obtained clarification from The State about any inconsistencies in the plan documents. Our auditors then used the benefit matrix as a cross-reference tool as they audited claims.

Findings

Our auditors did not identify any inconsistencies, ambiguities, or missing provisions in our Plan Documentation Analysis.

100% ELECTRONIC SCREENING WITH TARGETED SAMPLE ANALYSIS

Objective

CTI's Electronic Screening and Analysis System (ESAS®) software identified and quantified potential claim administration payment errors. The State and BCBSMT should talk about any verified under- or overpayments to determine the appropriate actions to correct any errors.

Scope

CTI electronically screened 100% of the service lines processed by BCBSMT during the audit period. The accuracy and completeness of BCBSMT's data directly impacted the screening categories we completed and the integrity of our findings. We screened the plan data for the following high-level ESAS categories to identify potential amounts at risk:

- Duplicate payments to providers and/or employees
- Plan exclusions and limitations
- Multiple surgical procedures
- Copayments, Deductibles, and Out of Pocket
- Coordination of Benefits
- Subrogation/Right of Recovery from Third Party
- Workers' Compensation
- Large Claim Review
- Case Management
- Fraud, Waste, and Abuse
- Preventive Services
- National Correct Coding Initiative and other Editing Compliance

Methodology

We used ESAS to analyze claim payment accuracy as well as any opportunities for system and process improvement. Using the data file provided by BCBSMT, we adjudicated each line on every claim the plan paid or denied during the audit period against the plan's benefits. Our Technical Lead Auditor tested a targeted sample of claims to provide insight into BCBSMT's claim administration as well as operational policies and procedures. We followed these procedures to complete our ESAS process:

- ***Electronic Screening Parameters*** – We relied on the plan document provisions to set the parameters in ESAS.
- ***Data Conversion*** – We converted and validated the claim data and compared it to the control totals provided by The State to check for reasonableness.
- ***Electronic Screening*** – We systematically readjudicated 100% of the service lines processed and flagged claims not administered according to plan parameters.
- ***Auditor Analysis*** – If claims within an ESAS screening category represented a material amount at risk, our auditors analyzed the findings to confirm results were valid. When using ESAS to identify payment errors, note that incomplete claim data could have led to false positives. CTI auditors made every effort to identify and remove false positives.

- ***Targeted Sample Analysis*** – From the categories identified with material amounts at risk, we selected the best examples of potential under- or overpayments to test. As cases were not randomly selected, we cannot extrapolate results. We selected up to 75 cases and sent BCBSMT an individual questionnaire for each. Targeted samples helped verify if the claim data supported our findings and if administration matched the plan's intent.
- ***Audit of Administrator Response and Documentation*** – We reviewed all responses and any additional supporting information provided. Based on this information and any additional analysis required, we removed false positives identified from the potential amounts at risk.

Findings

While we are confident in the accuracy of our ESAS results, note the dollar amounts associated with the results represent potential payment errors and process improvement opportunities. We would have to perform additional testing to substantiate the findings that could then provide the basis for remedial action planning or reimbursement.

The following report shows, by category, the number of line items or claims and the total potential amount at risk remaining at the conclusion of our analysis, targeted samples, and removal of verified false positives. Following the report is a detailed explanation of our results with findings for all screening categories where process improvement, recovery or savings opportunities exist. The administrator responses are copied directly from BCBSMT's reply to the audit findings.

The amounts shown in the Allowed and Paid/At Risk column are derived from CTI's compilation and summary of the claim data submitted by BCBSMT. The Charge amount represents fees billed by providers prior to application of provider discounts, reductions for excluded or limited services, and modifiers to procedure codes which reduce provider fees. The Paid/At Risk amount is determined as follows. As an example, CTI's screening showed $5,784,325 in total claim amounts for which the copay for specialist office visits may not been applied correctly. CTI considers the $474,762, which is the total amount of copayments for specialists that may not have been applied correctly for those same claims to be "at risk". This amount includes both potential underpayments as well as potential overpayments. Further review is required to verify the Paid/At Risk amount based on the specialty physician types assigned by BCBSMT. Similar review is required for all other categories in which errors were identified through our analysis. This additional layer of review will occur following presentation of audit results and further discussion with the State and BCBSMT.

It is important to note that even if the sampled claim was subsequently corrected prior to CTI's audit, we have still cited the error so you can discuss how to reduce errors and re-work in the future with your administrator.

Recommended Categories for Additional Testing					
Client: The State **Screening Period:** January 1, 2023 through March 31, 2023					
Category	**Lines**	**Claimants**	**Charge**	**Allowed**	**Paid/At Risk**
Duplicate Payments					
Providers and/or Employees	194	56	$48,126	$32,720	$23,617
Plan Limitations					
Nutritional Counseling 3 Visits/CY with Diabetes	15	2	$1,847	$1,439	$1,439
Deductible Over-Accumulation					
Individual In-Network	160	16	$48,982	$30,434	$2,185
Copay Application					
Office Visit (Specialist)	51,639	8,178	$8,808,410	$5,784,325	$474,762
Procedure to Procedure					
Outpatient Hospital	12	10	$7,067	$4,927	$4,927
Preventive Services					
With Copay Applied	16	16	$2,750	$2,056	$520
Fraud, Waste, and Abuse (Additional Observations Only)					
Spinal Region Upcoding	2,623	818	$170,098	$136,779	$74,260
High Severity ER Visits	493	443	$597,889	$452,248	$452,248

Electronic screening of all service lines processed revealed the potential for incorrectly paid claims. After review of the response and additional information provided by the administrator, CTI confirmed the potential for process improvement. Further testing is recommended.

ESAS Findings Detail Report				
QID	**Under/ Over Paid**	**BCBSMT Response**	**CTI Conclusion**	**Manual or System**
Duplicate Payments				
49	$297.87	**Original Response:** Agree. Per phone call to provider, the services are duplicates. The operator allowed the duplicate to pay because there was an additional service, and the primary diagnosis is different. An adjustment and refund have not been completed at this time. **BCBSMT Draft Response:** Agree to Out of Sample. The sample claim paid correctly since it processed on 03/06/2023, prior to the duplicate. DCN [redacted] was finalized on 03/14/2023 so this is an out of sample error for allowing the duplicate. Per phone call to provider, the services are duplicates. The operator allowed the duplicate to pay because there was an additional service, and the primary diagnosis is different. BCBSMT agrees to an out of sample overpayment of $297.87. (JP 06/14/2023)	Procedural deficiency and overpayment remain due to duplicate charges being paid.	☒ M ☐ S
50	$1,486.02	**Original Response:** Agree. The operator allowed the duplicate to pay because the revenue codes (301 vs 310) are different. After review, it appears the provider billed an inverted revenue code with the same HCPC code so this claim should be denied as a duplicate. An adjustment and refund have not been completed at this time. **BCBSMT Draft Response:** Agree to out of sample - The sample claim paid correctly since it processed on 02/25/2023, prior to the duplicate. DCN [redacted] was finalized on 02/27/2023 so this is an out of sample error for allowing the duplicate. The duplicate allowed because the revenue codes (301 vs 310) are different. After review, it appears the provider billed an inverted revenue code with the same HCPC code so this claim should be denied as a duplicate. BCBSMT agrees to an out of sample overpayment of $1486.02. (JP 06/14/2023)	Procedural deficiency and overpayment remain due to duplicate charges being paid.	☒ M ☐ S
Plan Limitations				
Nutritional Counseling 3 Visits Per Calendar Year with Diabetes				
67	$171.37	**Original Response:** Agree. This was the 4th treatment and allowed in error. All claims after this claim denied correctly. **BCBSMT Draft Response:** Agree. This was the 4th treatment and allowed in error. All claims after this claim denied correctly. BCBSMT will agree to an overpayment of $171.37. (JP 06/14/2023)	Procedural deficiency and overpayment remain as a fourth treatment was incorrectly allowed and paid.	☒ M ☐ S
Deductible Over-Accumulation				
Individual In-Network				
23	$690.44	**Original Response:** Agree. The claims for the dependent processed under 2 different subscripts so it overapplied the accums. The claims have not been adjusted to correct.	Procedural deficiency and underpayment remain as the member's claims are being processed under two	☒ M ☐ S

ESAS Findings Detail Report				
QID	**Under/ Over Paid**	**BCBSMT Response**	**CTI Conclusion**	**Manual or System**
		BCBSMT Draft Response: Agree to Out of Sample. The sample claim processed to apply deductible correctly under the correct subscript. The claims history for the dependent processed under 2 different subscripts so the overall accums were overapplied. BCBSMT will agree to an out of sample error of $690.44. The subscript was corrected, and claims adjusted to the right subscript on 06/03/2023. (JP 06/14/2023)	different subscripts incorrectly. The over-accumulation has not been adjusted.	
Copay Application				
Office Visit (Specialist)				
25	$15.00	**Original Response:** Disagree. The line is billed for 2 days so 2 copays applied. **BCBSMT Draft Response:** Disagree. The claim is coded to apply the copay per day billed, not units. If the units applied the copay, then the claim would overapply if 1 day was billed with 10 units. Per the group benefits, Naturopath is considered a PCP so the $25 copay per day applied correctly. Please see attached. (JP 06/14/2023)	Procedural deficiency and underpayment remain. While the bill shows service dates of 2/1/23 and 2/2/23, only one unit was billed. Based on Provider Specialty Codes spreadsheet provided on the BCBS desktop, provider type 374 is Doctor of Oriental Medicine, therefore the specialist copy of $35.00 should apply to the one office visit billed. Further, an NPI and taxonomy code look up indicated the provider is a naturopath.	☒ M ☐ S
26	$60.00	**Original Response:** Agree. The claim applied a $50.00 copay per line, so the copays were overapplied. The claim was adjusted to correct the copays on 4/17/23. **BCBSMT Draft Response:** Agree - The claim applied $50 copays instead of $25 copays in error. BCBSMT will agree to an underpayment of $100.00. (JP 06/14/2023)	Procedural deficiency and underpayment remain as four $50.00 copays were applied, one to each line of service, rather than the $25.00 copay per each of the four lines of service applicable.	☒ M ☐ S
Procedure to Procedure				
Outpatient Hospital				
13	$869.92	**Original Response:** Agree. Lines 4, 5 & 6 were paid in error. The services should have denied as inclusive to 0202U. The claim overpaid $869.92. An adjustment has not been completed at this time. **BCBSMT Draft Response:** Agree - The original claim was manually calced per lock 1689385. The calc overrode the G denials on lines 4-6. These are not COVID lab services so they should have denied. BCBSMT will agree to an overpayment of $869.94. (JP 06/14/2023)	Procedural deficiency and overpayment remain the services in lines 4, 5 & 6 were incorrectly paid. The claim has not been adjusted.	☒ M ☐ S

Additional Observations

During the ESAS review, our auditor observed the following procedures or situations that may not have caused an error on the sampled claim but may impact future claims or overall quality of service.

Observation	QID Number
Original Response: Preventive Services with Copay Applied – Typically, CTI sees the combination of CPT 99203 with diagnosis Z1211 for a preop/consult payable with no cost share. **BCBSMT Draft Response**: Disagree – The diagnosis code billed on the claim is routine and not preventive. A routine diagnosis will pay based on the regular medical benefits and apply a copay. Please see below email from our derivation area. [redacted]	19
Original Response: FWA Chiropractic Upcoding – The diagnoses billed support two Spinal Regions rather than the five or more Spinal Regions for the CPT code (98942) submitted. **BCBSMT Draft Response:** This specific billing situation is not systematically reviewed to compare the number of regions supported by the diagnosis versus that of the procedure. BCBSMT is currently looking at various ways to handle these types of scenarios including reviewing claim data and sending provider education letters when appropriate.	56, 57 and 58
Original Response: FWA High Severity ER Visits – The facility fees (one sample each for St. Peter's Hospital Missoula, St. Patrick Hospital Helena, Community Hospital Anaconda, Bozeman Health DEA and Billings Clinic Hospital) billed CPT 99285 (high level of Medical Decision Making (MDM)) and the professional services billed CPT 99284 (moderate level of MDM). There was no investigation performed by BCBSMT into the variance between the level of care billed for the facility service and the level of care billed for the professional service. **BCBSMT Draft Response**: Please note that the pricing for the facility claim is not impacted by the difference in the CPT codes. The allowance is the same amount with 99284 as it is with 99285.	62, 63, 64, 65 and 66

CONCLUSION

We consider it a privilege to have worked for, and with, your staff and administrator. Our contract offers eight hours of post-audit time to help you develop an implementation plan should The State desire additional assistance in that regard.

Thank you again for choosing CTI.

APPENDIX – ADMINISTRATOR RESPONSE TO DRAFT REPORT

Please note that any additional information submitted to CTI in response to the draft report from the administrator is reviewed, and observations may be removed prior to the final report being published. While a removed observation will not be included in the final report, it may be referenced in the administrator's response that follows.

BlueCross BlueShield of Montana

July 26, 2023

Daniel Montgomery
Claim Technologies Inc.
100 Court Ave., Ste 306
Des Moines, IA 50309

RE: Medical Plan Audit and Performance Evaluation – the State of Montana

Dear Auditor:

Attached is BCBSMT's response to the draft of CTI's audit report regarding the medical plan audit and performance evaluation conducted on behalf of the State of Montana. Excerpts from your report are in black; BCBSMT's responses are in blue. It is our request that this response be included in your final report to the State of Montana.

If you have any questions, please contact me at 940.397.9397

Sincerely,

Matt Scibek

Matt Scibek, Sr. Audit Specialist
Customer Audit
Audit & Performance Services

copy:
Shannon Bernas
Chuck Martin

BLUE CROSS AND BLUE SHIELD OF MONTANA RESPONSE TO THE DRAFT AUDIT REPORT

CTI on behalf of the State of Montana

Performance Evaluation of Claim Administration Services
For the period 01/01/2023 through 03/31/2023

July 2023

This is BCBSMT's response to CTI's draft audit report regarding the medical plan audit conducted on behalf of the State of Montana. Excerpts from CTI's report are in black text. BCBSMT's responses are in blue text.

ESAS Findings Detail Report				
QID	**Under/ Over Paid**	**BCBSMT Response**	**CTI Conclusion**	**Manual or System**
Duplicate Payments				
49	$297.87	**Original Response:** Agree. Per phone call to provider, the services are duplicates. The operator allowed the duplicate to pay because there was an additional service, and the primary diagnosis is different. An adjustment and refund have not been completed at this time. **BCBSMT Draft Response:** Agree to Out of Sample. The sample claim paid correctly since it processed on 03/06/2023, prior to the duplicate. DCN 306250008U50X was finalized on 03/14/2023 so this is an out of sample error for allowing the duplicate. Per phone call to provider, the services are duplicates. The operator allowed the duplicate to pay because there was an additional service, and the primary diagnosis is different. BCBSMT agrees to an out of sample overpayment of $297.87. (JP 06/14/2023) BCBCMT Response - The out of sample claim was adjusted to deny and a refund in the amount of $297.87 was initiated on 06/20/2023. Feedback was provided to the operator on 06/20/2023.	Procedural deficiency and overpayment remain due to duplicate charges being paid.	☒ M ☐ S
50	$1,486.02	**Original Response:** Agree. The operator allowed the duplicate to pay because the revenue codes (301 vs 310) are different. After review, it appears the provider billed an inverted revenue code with the same HCPC code so this claim should be denied as a duplicate. An adjustment and refund have not been completed at this time. **BCBSMT Draft Response:** Agree to out of sample - The sample claim paid correctly since it processed on 02/25/2023, prior to the duplicate. DCN 30565077A190X was finalized on 02/27/2023 so this is an out of sample error for allowing the duplicate. The duplicate allowed because the revenue codes (301 vs 310) are different. After review, it appears the provider billed an inverted revenue code with the same HCPC code so this claim should be denied as a duplicate. BCBSTX agrees to an out of sample overpayment of $1,486.02. (JP 06/14/2023) BCBSMT Response - The out of sample claim was adjusted to deny and a refund in the amount of $1,486.02 was initiated on 06/20/2023.	Procedural deficiency and overpayment remain due to duplicate charges being paid.	☒ M ☐ S

Plan Limitations				
Nutritional Counseling 3 Visits Per Calendar Year with Diabetes				
67	$171.37	**Original Response:** Agree. This was the 4th treatment and allowed in error. All claims after this claim denied correctly. **BCBSMT Draft Response:** Agree. This was the 4th treatment and allowed in error. All claims after this claim denied correctly. BCBSMT will agree to an overpayment of $171.37. (JP 06/14/2023) BCBSMT Response - The claim was adjusted to deny and a refund in the amount of $171.37 was initiated on 06/14/2023. Feedback was provided to the operator on 06/20/2023.	Procedural deficiency and overpayment remain as a fourth treatment was incorrectly allowed and paid.	☒ M ☐ S
Deductible Over-Accumulation				
Individual In-Network				

ESAS Findings Detail Report

QID	Under/ Over Paid	BCBSMT Response	CTI Conclusion	Manual or System
23	$690.44	**Original Response:** Agree. The claims for the dependent processed under 2 different subscripts so it overapplied the accums. The claims have not been adjusted to correct. **BCBSMT Draft Response:** Agree to Out of Sample. The sample claim processed to apply deductible correctly under the correct subscript. The claims history for the dependent processed under 2 different subscripts so the overall accums were overapplied. BCBSMT will agree to an out of sample error of $690.44. The subscript was corrected, and claims adjusted to the right subscript on 06/03/2023. (JP 06/14/2023) BCBSMT Response - The out of sample claims were adjusted on 06/03/2023 to pay the additional funds. Feedback was provided to the operator on 06/20/2023.	Procedural deficiency and underpayment remain as the member's claims are being processed under two different subscripts incorrectly. The overaccumulation has not been adjusted.	☒ M ☐ S

Copay Application				
Office Visit (Specialist)				
25	$15.00	**Original Response:** Disagree. The line is billed for 2 days so 2 copays applied. **BCBSMT Draft Response:** Disagree. The claim is coded to apply the copay per day billed, not units. If the units applied the copay, then the claim would overapply if 1 day was billed with 10 units for example. Per the group benefits, Naturopath is considered a PCP so the $25.00 copay per day applied correctly. Please see attached. (JP 06/14/2023) BCBSMT Response – BCBSMT maintains our disagree. The claim is processed correctly as billed.	Procedural deficiency and underpayment remain. While the bill shows service dates of 2/1/23 and 2/2/23, only one unit was billed. Based on Provider Specialty Codes spreadsheet provided on the BCBS desktop, provider type 374 is Doctor of Oriental Medicine, therefore the specialist copy of $35.00 should apply to the one office visit billed. Further, an NPI and taxonomy code look up indicated the provider is a naturopath.	☒ M ☐ S
26	$60.00	**Original Response:** Agree. The claim applied a $50.00 copay per line, so the copays were overapplied. The claim was adjusted to correct the copays on 4/17/23. **BCBSMT Draft Response:** Agree - The claim applied $50 copays instead of $25 copays in error. BCBSMT will agree to an underpayment of $100.00. (JP 06/14/2023) BCBSMT response – BCBSMT agrees to an underpayment of $100.00. The error was discovered in April 2023 and was due to the claim doubling the copay in error. After review, it was determined that the system was doubling the copays on initial process, but the adjustments are processing with the correct coding. The root cause is under investigation. BCBSMT is actively monitoring the State of Montana claims for potential impacts. The audit claim was adjusted on 04/17/2023 to pay the additional funds.	Procedural deficiency and underpayment remain as four $50.00 copays were applied, one to each line of service, rather than the $25.00 copay per each of the four lines of service applicable.	☒ M ☐ S

Procedure to Procedure				
Outpatient Hospital				
13	$869.92	**Original Response:** Agree. Lines 4, 5 & 6 were paid in error. The services should have denied as inclusive to 0202U. The claim overpaid $869.92. An adjustment has not been completed at this time. **BCBSMT Draft Response:** Agree - The original claim was manually calced per lock 1689385. The calc overrode the G denials on lines 4-6. These are not COVID lab services so they should have denied. BCBSMT will agree to an overpayment of $869.94. (JP 06/14/2023) BCBSMT Response – The claim was adjusted to deny and a refund in the amount of $869.94 was initiated on 06/14/2023. The refund is currently pending. Feedback was provided to the operator on 06/20/2023.	Procedural deficiency and overpayment remain the services in lines 4, 5 & 6 were incorrectly paid. The claim has not been adjusted.	☒ M ☐ S

Additional Observations

During the ESAS review, our auditor observed the following procedures or situations that may not have caused an error on the sampled claim but may impact future claims or overall quality of service.

Observation	QID Number
Original Response: Preventive Services with Copay Applied – Typically, CTI sees the combination of CPT 99203 with diagnosis Z1211 for a preop/consult payable with no cost share. **BCBSMT Draft Response**: Disagree – The diagnosis code billed on the claim is routine and not preventive. A routine diagnosis will pay based on the regular medical benefits and apply a copay. Please see below email from our derivation area. (JP 06/14/2023) BCBSMT Response – Maintain our disagree. The claim is processed correctly as billed.	19
Original Response: FWA Chiropractic Upcoding – The diagnoses billed support two Spinal Regions rather than the five or more Spinal Regions for the CPT code (98942) submitted. Need BCBSMT Draft Response: BCBSMT Response – This specific billing situation is not systematically reviewed to compare the number of regions supported by the diagnosis versus that of the procedure. BCBSMT is currently looking at various ways to handle these types of scenarios including reviewing claim data and sending provider education letters when appropriate.	56, 57 and 58
Original Response: FWA High Severity ER Visits – The facility fees (one sample each for St. Patrick Hospital Missoula, St. Patrick Hospital Helena, Community Hospital Anaconda, Bozeman Health DEA and Billings Clinic Hospital) billed CPT 99285 (high level of Medical Decision Making (MDM)) and the professional services billed CPT 99284 (moderate level of MDM). There was no investigation performed by BCBSMT into the variance between the level of care billed for the facility service and the level of care billed for the professional service. **BCBSMT Draft Response**: Please note that the pricing for the facility claim is not impacted by the difference in the CPT codes. The allowance is the same amount with 99284 as it is with 99285.	62, 63, 64, 65 and 66

BCBSMT Response – BCBSMT maintains our previous response in that the CPT billed in this claim situation has no impact on the claim allowance or payment.	

Comprehensive Claim Administration Audit

EXECUTIVE SUMMARY REPORT

State of Montana Medical Plan

Administered by Blue Cross Blue Shield of Montana

Audit Period: January 1, 2023 through December 31, 2023

Presented to

State of Montana

September 2024

CLAIM TECHNOLOGIES INCORPORATED

PART OF THE BROWN & BROWN TEAM

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INTRODUCTION

This ***Executive Summary*** contains CTI's findings and recommendations from our audit of Blue Cross Blue Shield of Montana's (BCBSMT) administration of the medical plan managed by the Health Care and Benefits Division within the Montana Department of Administration and subject to the oversight of the State of Montana Legislative Audit Division (the State). You can review the detail that supports CTI's findings and recommendations in our ***Specific Findings Report***.

CTI specializes in the audit and control of health plan claim administration. Accordingly, the statements we make relate narrowly and specifically to the overall effectiveness of policies, procedures, and systems BCBSMT used to pay the State's claims during the audit period.

CTI conducted the audit according to accepted standards and procedures for claim audits in the health insurance industry. We based our audit findings on the data and documentation provided by the State and BCBSMT. The validity of our findings relies on the accuracy and completeness of that information. We planned and performed the audit to gain reasonable assurance that claims were adjudicated consistently and accurately in relationship to the policy provisions and administrative agreement between the State and BCBSMT. As required by the State, a draft of this report was also reviewed by certified public accountant, Nick George, of Brown & Brown Insurance. While he did not review source documentation, no exceptions to our findings were noted.

While performing the audit, CTI complied with all confidentiality, non-disclosure, and conflict of interest requirements and did not receive anything of value or any benefit of any kind other than agreed upon audit fees.

OBJECTIVES AND SCOPE

The objectives of CTI's audit of BCBSMT's claim administration were to determine whether:

- BCBSMT followed the terms of its contract with the State;
- BCBSMT paid claims according to the provisions of the plan documents and if those provisions were clear and consistent;
- members were eligible and covered by the State's plans at the time a service paid by BCBSMT was incurred; and
- any claim administration systems or processes need improvement.

CTI audited BCBSMT's claim administration of the the State medical plans for the period of January 1, 2023 through December 31, 2023. The population of claims and amount paid during that period were:

Total Paid Amount	$124,487,779
Total Number of Claims Paid/Denied/Adjusted	386,475

The audit included the following components which are described in greater detail on the following pages:

- Random Sample Audit of 180 Claims
- 100% Electronic Screening with 30 Targeted Samples
- Operational Review and Questionnaire
- Plan Documentation Analysis

AUDIT FINDINGS AND RECOMMENDATIONS

Random Sample Findings

CTI validated claim processing accuracy based on a sample of 180 medical claims paid or denied by BCBSMT during the audit period. We selected the random sample to provide a statistical confidence level of 95% +/- 3% margin of error.

CTI's Random Sample Audit categorizes errors into key performance indicators. We use this systematic labeling of errors and calculation of performance as the basis for the benchmarks generated using results from our most recent 100 medical claim audits.

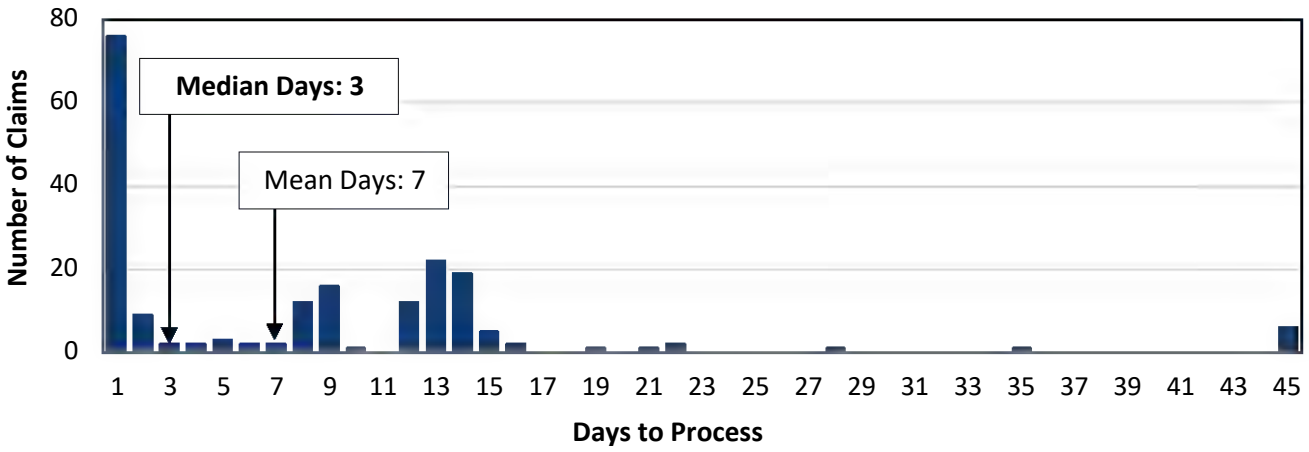
The following table illustrates BCBSMT's performance was above the median in all three of CTI's benchmarked performance indicators. The three errors identified were related to PPO contract pricing application.

Key Performance Indicators	Administrator's Performance by Quartile				
	Quartile 1	Quartile 2	MEDIAN	Quartile 3	Quartile 4
	Lowest →				*Highest*
Financial Accuracy: Compares total dollars associated with correct claim payments to total dollars of correct claim payments that should have been made.			98.90%	99.78%	
Accurate Payment: Compares number of correctly paid claims to total number of claims paid.			97.60%		99.44%
Accurate Processing: Compares number of claims processed without any type of error (financial or non-financial) to total number of claims processed.			97.11%		99.44%

Claim Turnaround Time

A final measure of claim administration performance is claim turnaround time. Through the audit sample, BCBSMT demonstrated its median turnaround time on a complete claim submission was 3 days from the date it received a complete claim to the date the claim was paid or denied.

Median and Mean Claim Turnaround



Random Sample Recommendation

The error identified during our audit was related to PPO pricing. It was a manual error regarding the number of service units for an air ambulance, which caused incorrect pricing to be applied. CTI recommends the State review this item with BCBSMT and confirm the appropriate coaching and system improvements occurred to ensure accurate pricing is applied going forward.

CTI identified a provider (licensed clinical social worker) that appeared to have an excessive amount of therapy sessions billed (based on time CPT code 90837). CTI recommended BCBSMT SID Unit to review, please refer to page 19 of the Specific Findings report for further information. BCBSMT's review did not determine there to be an issue for this member. However, CTI recommends the State and BCBSMT discuss these findings and continue to monitor for these types of potential overbilling practices by providers

CTI further recommends the State perform periodic due diligence follow-up audits to ensure BCBSMT continues to perform at a high level, and no new processing issues occur.

100% Electronic Screening with Targeted Samples Findings

We used our proprietary Electronic Screening and Analysis System (ESAS) software to further analyze claim payment accuracy as well as any opportunities for system and process improvement. Using the data file provided by BCBSMT, we adjudicated each line on every claim the plan paid or denied during the audit period against the plan's benefits. Our Technical Lead Auditor tested a targeted sample of 30 claims to provide insight into BCBSMT's claim administration as well as operational policies and procedures.

The following table shows the medical services identified as potentially overpaid. It is important to note that the amount shown represents potential payment errors; additional testing would be required to substantiate the findings and provide the basis for remedial action planning or recovery.

ESAS Candidates for Additional Testing	Paid/At Risk
Duplicate Payments	**$86,392**
Excluded Services	**$21,523**
Infertility Treatment	$11,414
Dental, Unlisted Surgical Procedures	$8,939
Dental, Extractions Other Impactions	$885
Hypnosis, Hypnotherapy	$285
Fraud Waste and Abuse – Non-Emergency Transport	**$5,977**
Plan Limitations – Intense Outpatient Therapy	**$69,871**
Preventive Services – With Deductible Applied	**$13,769**

For specific information on the over and underpayments identified, see the ESAS section of CTI's ***Specific Findings Report***.

100% Electronic Screening with Targeted Samples Recommendations

The State should talk to BCBSMT about conducting a focused analysis of the errors identified through ESAS to determine if overpayment recovery and/or system improvements are possible and to reduce or eliminate similar errors going forward. For the issues identified by ESAS, CTI can prepare claim detail for BCBSMT to use in its analysis.

Operational Review Findings

BCBSMT completed our Operational Review Questionnaire and provided information on its:

- Systems, staffing, and workflow;
- Claim administration and eligibility maintenance procedures; and
- Internal control risk mechanisms, e.g., HIPAA protections; internal audit policies and practices; and fraud, waste, and abuse detection and prevention.

Our Operational Review indicated:

- BCBSMT and the State had a performance agreement with guarantees for the categories of Service and Claim, Implementation, Reporting, Account Management, Provider Reimbursement and Multiple of Medicare Discount Guarantee. BCBSMT provided performance reports for 2023 for Claim Quality and Claims Timeliness as well as for Customer Service. In 2023, BCBSMT did not achieve the target performance goal for Provider and Member Satisfaction, with results of 74.0% and 78.5%, respectively. The goal for these measures were 85.0%. Consequently, BCBSMT issued a settlement credit to the State on April 24, 2024. However, due to a calculation error, BCBSMT had to request repayment. Therefore, as of the date of issuance of this report, BCBSMT has not provided the final payment to the State. BCBSMT measured its performance specifically for the State, a best practice in contrast to administrators who report performance at a service center or book of business level. It should be noted that the Multiple of Medicare Discount Guarantee was not completed by the date of the issuance of this report (Due May 31 each year).
- Based on claim data provided for the audit period, BCBSMT achieved the following overall provider discounts (both network and non-network) for the State's members during the audit period. Note that discount amounts shown exclude members 65 and older and include only those claims where the allowed amount was greater than zero. In comparison to the previous year's discount level, BCBSMT was slightly lower. However, CTI conducted a monthly analysis of claims paid for the same period of time and the overall payment was equal to or lower than the previous year's claim experience.

Total of All Claims		
Claim Type	**Provider Discount**	
Ancillary	$3,127,685.46	34.6%
Non-Facility	$27,174,614.31	35.3%
Facility Inpatient	$9,770,729.35	29.2%
Facility Outpatient	$24,152,210.69	27.0%
Total	**$64,225,239.81**	**30.7%**

- BCBSMT performed Coordination of Benefits (COB) as outlined in the State's summary plan description. It provided a COB savings report for the first three quarters 2023 (4th quarter results were not available at the time of this report) showing $46,815,404 in savings, including savings related to Medicare coordination. This amount represented 37.6% of paid claims.

- BCBSMT reported 96.4% of claims were submitted electronically; 60.9% auto adjudicated (finalized without claim examiner review) since all required claim elements were present on the claim.
- BCBSMT kept an internal log to track appeal timeframes and resolution. BCBSMT provided a 2023 summary report that showed 257 appeals, 75% of which were upheld. In addition, 100% of appeals were handled timely.
- During the audit period, BCBSMT reported it did not have any breaches triggering notification requirements for the State.

Performance Guarantee Validation
The contract between BCBSMT and the State included performance guarantees.

The performance guarantee was based on BCBSMT's internal random audit policies and procedures and included a target of 98% for Payment Accuracy (defined as claims adjudicated for the correct amount). Based on CTI's audit, BCBSMT surpassed this performance guarantee. BCBSMT achieved 99.44% for Payment Accuracy. It should be noted there was not a performance guarantee for Financial Accuracy.

BCBSMT's self-reported performance against guarantees was 100% for the overall category of Payment Accuracy, 99.6% for Procedural Accuracy, and 100% for Financial Accuracy.

Operational Review Recommendations
BCBSMT should amend its performance guarantee to include a measure for financial accuracy performance.

Plan Documentation Analysis Findings and Recommendations
Our auditors did not identify any inconsistencies, ambiguities, or missing provisions in our Plan Documentation Analysis.

CONCLUSION

We understand you will need to review these findings and recommendations to determine your priorities for action. Should the State desire additional assistance with this, our contract offers eight hours of post-audit time to help you create an implementation plan.

CTI also suggests that the State perform a follow-up audit to ensure BCBSMT continues to perform above benchmark, and that no new processing issues occur.

We consider it a privilege to have worked with the State and your staff. We welcome any opportunity to assist you in the future. Thank you again for choosing CTI.

This document has been prepared in good faith on the basis of information provided to Claim Technologies Incorporated, without any independent verification. If the data, information, and observations received are inaccurate or incomplete, our review, analysis, and conclusions may likewise be inaccurate or incomplete. Our conclusions and recommendations are developed after careful analysis and reflect our best professional judgment.

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CLAIM TECHNOLOGIES INCORPORATED

PART OF THE BROWN & BROWN TEAM

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Comprehensive Claim Administration Audit

SPECIFIC FINDINGS REPORT

State of Montana Medical Plan

Administered by Blue Cross Blue Shield of Montana

Audit Period: January 1, 2023 through December 31, 2023

Presented to

State of Montana

September 2024

CLAIM TECHNOLOGIES INCORPORATED

PART OF THE BROWN & BROWN TEAM

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INTRODUCTION

This ***Specific Findings Report*** contains CTI's findings and recommendations from our audit of Blue Cross Blue Shield of Montana's (BCBSMT) administration of medical plan managed by the Health Care and Benefits Division within the Montana Department of Administration and subject to the oversight of the State of Montana Legislative Audit Division (the State). The statistics, observations, and findings in this report constitute the basis for the analysis and recommendations presented under separate cover in the ***Executive Summary***. We provide this report to the State, the plan sponsor, and BCBSMT, the claims administrator. A copy of BCBSMT's response to these findings can be found in Appendix B of this report.

CTI specializes in the audit and control of health plan claim administration. Accordingly, the statements we make relate narrowly and specifically to the overall effectiveness of policies, procedures, and systems BCBSMT used to pay the State's claims during the audit period.

CTI conducted the audit according to accepted standards and procedures for claim audits in the health insurance industry. We based our audit findings on the data and documentation provided by the State and BCBSMT. The validity of our findings relies on the accuracy and completeness of that information. We planned and performed the audit to gain reasonable assurance that claims were adjudicated consistently and accurately in relationship to the policy provisions and administrative agreement between the State and BCBSMT. As required by the State, a draft of this report was also reviewed by certified public accountant, Nick George, of Brown & Brown Insurance. While he did not review source documentation, no exceptions to our findings were noted.

While performing the audit, CTI complied with all confidentiality, non-disclosure, and conflict of interest requirements and did not receive anything of value or any benefit of any kind other than agreed upon audit fees.

Audit Objectives

The objectives of CTI's audit of BCBSMT's claim administration were to determine whether:

- BCBSMT followed the terms of its contract with the State;
- BCBSMT paid claims according to the provisions of the plan documents and if those provisions were clear and consistent;
- members were eligible and covered by the State's plans at the time a service paid by BCBSMT was incurred; and
- any claim administration systems or processes need improvement.

Audit Scope

CTI audited BCBSMT's claim administration of the State's medical plans for the period of January 1, 2023 through December 31, 2023. The population of claims and amount paid during that period were:

Total Paid Amount	$124,487,779
Total Number of Claims Paid/Denied/Adjusted	386,475

The audit included the following components:

1. **Operational Review**
    - Claim administrator information
    - Claim administrator claim fund account
    - Claim adjudication and eligibility maintenance procedures
    - HIPAA compliance

2. **Plan Documentation Analysis**
    - Plan documents and other approved communications
    - Identify missing provisions, ambiguities, and inconsistencies
    - Administrative services agreement

3. **100% Electronic Screening with 30 Targeted Samples**
    - Systematic analysis of 100% of paid claims
    - Problem identification and quantification

4. **Random Sample Audit of 180 Claims**
    - Statistical confidence at 95% +/- 3%
    - Key Indicator performance levels
    - Benchmarking
    - Identify and prioritize problems

OPERATIONAL REVIEW

Objective

CTI's Operational Review evaluates BCBSMT's claim administration systems, staffing, and procedures to identify any deficiencies that materially affect its ability to control risk and pay claims accurately on behalf of the plan.

Scope

The scope of the Operational Review included:

- Claim administrator information
  - Insurance and bonding
  - Conflicts of interest
  - Financial reporting
  - Business continuity planning
  - Claim payment system and coding protocols
  - Data and system security
- Claim funding
  - Claim funding mechanism
  - Check processing and security
  - Large claim payment process
- Claim adjudication, customer service, and eligibility maintenance procedures
  - Exception claim processing
  - Eligibility maintenance and investigation
  - Other insurance coverage and adjudication
  - Overpayment recovery
  - Network utilization
  - Utilization review, case management, and disease management
  - Subrogation and other third-party liability
  - Appeals processing
- HIPAA compliance

Methodology

CTI used an Operational Review Questionnaire to gather information from BCBSMT. We modeled our questionnaire after the audit tool used by certified public accounting firms when conducting a Systems and Organization Controls (SOC) audit of a service administrator. We modified that tool to elicit information specific to the administration of your plan.

We reviewed BCBSMT's responses and any supporting documentation supplied to gain an understanding of the procedures, staffing, and systems used to administer the State's plans. This allowed us to conduct the audit more effectively.

Findings

We observed the following:

- BCBSMT indicated it maintained levels and types of insurance reasonable and customary for a health services organization with comparable size and market presence. In addition, the levels were in accordance with the agreement between the State and BCBSMT.
- BCBSMT and the State had a performance agreement with guarantees for the categories of Service and Claim, Implementation, Reporting, Account Management, Provider Reimbursement and Multiple of Medicare Discount Guarantee. BCBSMT provided performance reports for 2023 for Claim Quality and Claims Timeliness as well as for Customer Service. In 2023, BCBSMT did not achieve the target performance goal for Provider and Member Satisfaction, with results of 74.0% and 78.5%, respectively. The goal for these measures were 85.0%. Consequently, BCBSMT issued a settlement credit to the State on April 24, 2024. However, due to a calculation error, BCBSMT had to request repayment. Therefore, as of the date of issuance of this report, BCBSMT has not provided the final payment to the State. BCBSMT measured its performance specifically for the State, a best practice in contrast to administrators who report performance at a service center or book of business level. It should be noted that the Multiple of Medicare Discount Guarantee was not completed by the date of the issuance of this report (Due May 31 each year).
- BCBSMT provided a copy of the System and Organization Controls (SOC 1) Type 2 report on the Description and Tests of Operating Effectiveness of the Claims Processing System for BCBSMT October 1, 2022 to September 30, 2023 issued by its external auditor Ernst & Young LLP. BCBSMT's Executive Director – Internal Audit provided a bridge letter indicating there were no material changes in controls through December 31, 2023. The report was issued in accordance with the requirements of the American Institute of Certified Public Accountants (the AICPA). Ernst & Young performed various testing procedures against the internal controls identified by BCBSMT in the following areas:
    - Control Environment
    - Communication and Information
    - Risk Assessment
    - Monitoring Activities
    - Control Activities
    - Logical and Physical Access Controls
    - System Operations
    - Change Management
    - Risk Mitigation
- BCBSMT has used Blue Chip claim administration software since 1985. BCBSMT also contracted with ClaimsXten to detect claim unbundling. BCBSMT indicated it adopted all NCCI edits.
- BCBSMT reported it utilized vendors for utilization management and overpayment collection services as it related to the State's account. For overpayment recovery services BCBSMT did not pass on the cost of those services. Therefore, the State was reimbursed the total overpayment amount.
- BCBSMT provider network utilization was high at 98%. The State's members traveling or domiciled outside of Montana accessed BCBS' national network, which helped drive network savings.
- Based on claim data provided for the audit period, BCBSMT achieved the following overall provider discounts (both network and non-network) for the State's members during the audit

period. Note that discount amounts shown exclude members 65 and older and include only those claims where the allowed amount was greater than zero. In comparison to the previous year's discount level, BCBSMT was slightly lower. However, CTI conducted a monthly analysis of claims paid for the same period of time and the overall payment was equal to or lower than the previous year's claim experience.

Total of All Claims		
Claim Type	**Provider Discount**	
Ancillary	$3,127,685.46	34.6%
Non-Facility	$27,174,614.31	35.3%
Facility Inpatient	$9,770,729.35	29.2%
Facility Outpatient	$24,152,210.69	27.0%
Total	**$64,225,239.81**	**30.7%**

- All BCBSMT claim system users maintained unique access passwords. System access and override authority for its employees was based on job description.
- Claims workflow was documented through a flow-chart that included the paths of processing for both electronic and paper claims. Decision points existed throughout the claims review process to ensure the inclusion of necessary provider information and other factors that might require pending a claim for review by a claim examiner (for example, accident information, medical records, coordination of benefits information). Claims that included all necessary information were approved for payment without manual review.
- BCBSMT had internal procedures to minimize potential overpayments, but when overpayments did occur, an overpayment request was sent. When overpayments were repaid, the claims were adjusted, and voids and refunds were reflected on the State's check register. BCBSMT reported refunds (both solicited and non-solicited) totaled $897,465 for the audit period.
- BCBSMT implemented procedures for coverage of telemedicine, COVID-19 vaccines with no cost-sharing, and COVID-19 testing in compliance with the FFCA and CARES acts. These procedures were discontinued May 12, 2023.
- BCBSMT performed Coordination of Benefits (COB) as outlined in the State's summary plan description. It provided a COB savings report for the first three quarters 2023 (4th quarter results were not available at the time of this report) showing $46,815,404 in savings, including savings related to Medicare coordination. This amount represented 37.6% of paid claims.
- BCBSMT provided copies of its internal procedures to demonstrate compliance with Medicare's demand letters to investigate and determine whether BCBSMT should be the primary payer for Medicare-eligible persons. BCBSMT also provided the CMS Mandatory Reporting procedures to demonstrate its compliance with federal law.
- BCBSMT reported 96.4% of claims were submitted electronically; 60.9% auto adjudicated (finalized without claim examiner review) since all required claim elements were present on the claim.
- BCBSMT identified potential Workers' Compensation claims through ICD-10 codes, provider notes, and member notification. These claims were denied until an accident claim form had been completed. There was no minimum in claim payments before an investigation was undertaken.

- BCBSMT performed precertification, large claim management and case/disease management. BCBSMT reported savings from case and disease management during 2023 was approximately $5,100,000.
- BCBSMT kept an internal log to track appeal timeframes and resolution. BCBSMT provided a 2023 summary report that showed 257 appeals, 75% of which were upheld. In addition, 100% of appeals were handled timely.
- BCBSMT's claim system did not track the date adjustments were identified; it defaulted to the original claim receipt date. As a result, BCBSMT excluded adjustments from claim turnaround time calculations and the corresponding performance guarantee.
- BCBSMT's comprehensive Special Investigations Department (SID) included proactive data analysis to detect outliers in provider behavior and billing practices. Dedicated staff was responsible for data mining and case triage. BCBSMT pursued full recovery of money lost due to fraud, waste, and abuse. Outcomes included provider education and, if warranted, civil action. Cases were also referred to appropriate local, state, or federal enforcement agencies when appropriate. BCBSMT's SID used multiple anti-fraud software solutions to proactively data mine for fraudulent or abusive billing patterns. The BCBSMT SID opened 11 (nine commercial and two Medicare Advantage) new health care fraud cases and closed 14 (12 commercial and two Medicare Advantage) cases in Montana. Seven cases included referral to the Montana insurance and/or licensing board. Three cases had information from the Montana Commissioner of Securities and Insurance which included warnings and a fine.
- BCBSMT compensated out-of-network providers using Medicare pricing (100% of Medicare for those providers in Montana and 300% for those providers outside of Montana). For those out of state claims, network pricing was obtained through the Blue Cross Blue Shield BlueCard national network.
- BCBSMT adopted procedures to conform with the federal No Surprises Act (NSA). Under the NSA, providers were prohibited from balance billing the member if they were paid the Qualifying Payment Amount (QPA). While BCBSMT did not provide its internal procedures for handling these types of claims, it did report nine member appeals for out-of-network services during 2023. Six of the nine appeals were upheld.
- BCBSMT employees received online HIPAA training annually and occasionally more often if warranted.
- During the audit period, BCBSMT reported it did not have any breaches triggering notification requirements for the State.

Performance Guarantee Validation

The contract between BCBSMT and the State included performance guarantees.

The performance guarantee was based on BCBSMT's internal random audit policies and procedures and included a target of 98% for Payment Accuracy (defined as claims adjudicated for the correct amount). Based on CTI's audit, BCBSMT surpassed this performance guarantee. BCBSMT achieved 98.33% for Payment Accuracy. It should be noted there was not a performance guarantee for Financial Accuracy.

BCBSMT's self-reported performance against guarantees was 100% for the overall category of Payment Accuracy, 99.6% for Procedural Accuracy, and 100% for Financial Accuracy.

PLAN DOCUMENTATION ANALYSIS

Objective

CTI's Plan Documentation Analysis evaluates the documents governing administration of the State's medical plans and identifies inconsistencies, ambiguities, or missing provisions that might negatively impact accurate claim administration. Through this evaluation, we gained an understanding of BCBSMT's administrative service responsibilities for the State's medical plans. This understanding allowed us to audit more effectively.

Scope

Our auditors evaluated the State's Wrap Plan document and Administrative Services Agreement.

Methodology

CTI obtained a copy of the plan documentation from the State and/or BCBSMT. Our auditors reviewed the applicable documents to better understand the provisions BCBSMT should have used to process and pay all medical claims.

Our auditors referenced these plan documents as they audited claims.

Findings

Our auditors did not identify any inconsistencies, ambiguities, or missing provisions in our Plan Documentation Analysis.

100% ELECTRONIC SCREENING WITH TARGETED SAMPLE ANALYSIS

Objective

CTI's Electronic Screening and Analysis System (ESAS®) software identified and quantified potential claim administration payment errors. The State and BCBSMT should talk about any verified under- or overpayments to determine the appropriate actions to correct any errors.

Scope

CTI electronically screened 100% of the service lines processed by BCBSMT during the audit period. The accuracy and completeness of BCBSMT's data directly impacted the screening categories we completed and the integrity of our findings. We screened the plan data for the following high-level ESAS categories to identify potential amounts at risk:

- Duplicate payments to providers and/or employees
- Plan exclusions and limitations
- Multiple surgical procedures
- Copayments, Deductibles, and Out of Pocket
- Coordination of Benefits
- Subrogation/Right of Recovery from Third Party
- Workers' Compensation
- Large Claim Review
- Case Management
- Fraud, Waste, and Abuse (FWA)
- Preventive Services
- National Correct Coding Initiative and other Editing Compliance

Methodology

We used ESAS to analyze claim payment accuracy as well as any opportunities for system and process improvement. Using the data file provided by BCBSMT, we adjudicated each line on every claim the plan paid or denied during the audit period against the plan's benefits. Our Technical Lead Auditor tested a targeted sample of claims to provide insight into BCBSMT's claim administration as well as operational policies and procedures. We followed these procedures to complete our ESAS process:

- ***Electronic Screening Parameters*** – We relied on the plan document provisions to set the parameters in ESAS.
- ***Data Conversion*** – We converted and validated the claim data and compared it to the control totals provided by the State to check for reasonableness.
- ***Electronic Screening*** – We systematically adjudicated 100% of the service lines processed and flagged claims not administered according to plan parameters.
- ***Auditor Analysis*** – If claims within an ESAS screening category represented a material amount at risk, our auditors analyzed the findings to confirm results were valid. When using ESAS to identify payment errors, note that incomplete claim data could lead to false positives. CTI auditors made every effort to identify and remove false positives.
- ***Targeted Sample Analysis*** – From the categories identified with material amounts at risk, we selected the best examples of potential under- or overpayments to test. As cases were not

randomly selected, we did not extrapolate results. We selected up to 30 cases and sent BCBSMT an individual questionnaire for each. Targeted samples helped verify if the claim data supported our finding and if BCBSMT's administration matched the plan's intent.

- ***Audit of Administrator Response and Documentation*** – We reviewed BCBSMT's response and any additional supporting information provided. Based on this information and any additional analysis required, if false positives were identified, we removed the identified claims from the potential amounts at risk.

Findings

While we are confident in the accuracy of our ESAS results, note the dollar amounts associated with the results represent potential payment errors and process improvement opportunities. We would have to perform additional testing to substantiate the findings that could then provide the basis for remedial action planning or reimbursement.

The following report shows, by category, the number of line items or claims and the total potential amount at risk remaining at the conclusion of our analysis, targeted samples, and removal of verified false positives. Following the report is a detailed explanation of our results with findings for all screening categories where process improvement, recovery or savings opportunities exist. The administrator responses are copied directly from BCBSMT's reply to the audit findings.

The amounts shown in the Potential Recovery column were derived from CTI's compilation and summary of the claim data submitted by BCBSMT. The Allowed amount represents the amount allowed after network discounts, usual and customary, or member cost share. The Potential Recovery amount includes overpayments only. Further administrator review would be required to verify the categories in which errors were identified through our analysis to validate the ***Potential Recovery*** amount. This additional layer of review will occur following presentation of audit results and further discussion with the State and BCBSMT.

It is important to note that even if the sampled claim was subsequently corrected prior to CTI's audit, we have still cited the error so you can discuss how to reduce errors and re-work in the future with your administrator.

Recommended Client-Specific ESAS Categories for Additional Testing				
Client: The State **Screening Period:** January 1, 2023 through December 31, 2023				
Category	**Lines**	**Claimants**	**Allowed**	**Potential Recovery**
Duplicate Payments				
Providers and/or Employees	791	217	$175,084	$86,392
Plan Exclusions				
Dental, Extractions Other Impactions	4	1	$1,180	$885
Dental, Unlisted Surgical Procedure	13	6	$11,665	$8,939
FWA Non-Emergency Transportation	1	1	$5,977	$5,977
Hypnosis, Hypnotherapy	2	1	$285	$285
Infertility Treatment	123	43	$15,364	$11,414
Plan Limitations				
Intense Outpatient	222	10	$125,805	$69,871

The amounts shown in the Allowed and At-Risk column were derived from CTI's compilation and summary of the claim data submitted by BCBSMT. The At-Risk amount was determined as follows. As an example, CTI's screening showed $175,084 in total allowed amounts that may include duplicate payments. CTI considers $86,392, which was the total amount of potential duplicates that may have been applied incorrectly, to be at risk. Similar review is required for all other categories in which errors were identified through our analysis. This additional layer of review will occur following presentation of audit results and further discussion with the State and BCBSMT.

Recommended Operational ESAS Categories for Additional Testing				
Client: The State **Screening Period:** January 1, 2023 through December 31, 2023				
Category	**Lines**	**Claimants**	**Allowed**	**At Risk**
Preventive Services				
With Deductible Applied	220	162	$51,686	$13,769

Electronic screening of all service lines processed revealed the potential for incorrectly paid claims. After review of the response and additional information provided by the administrator, CTI confirmed the potential for process improvement. Further testing is recommended.

ESAS Findings Detail Report				
QID	**Under/ Over Paid**	**BCBSMT Response**	**CTI Conclusion**	**Manual or System**
Duplicate Payments				
12	$161.55	Agree. Claim was adjusted 5/7/24.	Procedural deficiency and overpayment identified. The claims were for the same service. The initial claim billed under the provider group and the second billed under the individual provider of service.	☒ M ☐ S
13	$106.72	Agree. The claims are billed by 2 different providers, upon further review, one provider was not credentialed and sent in a corrected claim to correct the provider's name. Claim was adjusted on 8/6/24. The duplicate claim applied to the member's deductible. Therefore, no financial impact.	Procedural deficiency and overpayment identified. The claims were for the same service. The initial claim processed as out-of-network and the second claim processed as in-network. The identical physical therapy services should not have paid twice on the same day.	☒ M ☐ S
14	$248.07	Agree. This claim was paid as a duplicate in error. BCBSMT has adjusted the claim 5/3/24.	Procedural deficiency and overpayment cited. The claims were for same service and paid twice.	☒ M ☐ S

ESAS Findings Detail Report				
QID	**Under/ Over Paid**	**BCBSMT Response**	**CTI Conclusion**	**Manual or System**
15	$200.00	Agree. Claim was adjusted on 8/6/24.	Procedural deficiency and overpayment identified. The claims were for identical services and should not have been allowed twice on the same day.	☒ M ☐ S
16	$0.00	Agree. The claims were billed with 2 different performing provider numbers providing the appearance that these are separate claims, so the duplicate paid in error. After review, the provider originally billed with clinic as performing provider and then submitted claim with actual performing provider. The original (DCN XXXXXXXXX020C) is the incorrect claim and should be denied as a duplicate. This claim paid out of net and completely to the deductible. BCBSMT will agree to a $0 non-financial error. BCBSMT adjusted 5/7/24.	Procedural deficiency cited. The claims were for same service. The initial claim billed under the provider group and the second was billed under the individual provider of service.	☐ M ☒ S
Plan Exclusions				
Dental, Extractions Other Impactions				
22	$1,044.26	Agree. The claims receive a prompt that advises them to review and determine if the services performed are covered. The operator allowed claim in error. State of Montana does not cover the removal of complete bony teeth. The claim should not have been allowed. BCBSMT is processing manual credit to the State as of 7/30/24.	Procedural deficiency and overpayment cited. This claim should have been denied.	☒ M ☐ S
Dental, Unlisted Surgical Procedure				
23	$5,582.14	Agree. A workaround stops claim for review of dental services billed. To determine eligibility. This code should have been reviewed for a description. BCBSMT has called the provider for a description of the service and will respond as soon as it is available. BCBSMT has issued a credit to the State on 5/9/24.	Procedural deficiency and overpayment identified. This claim should have been denied.	☒ M ☐ S
Infertility Treatment				
26	$90.00	Agree. BCBSMT will issue a credit for 2 claims in the member's history affected by this issue that totaled an overpayment of $102.47.	Procedural deficiency and overpayment identified. Per page 31 of the plan booklet, charges related to the reversal of an elective sterilization were not covered. This claim was for anesthesia related to the reversal of an elective sterilization and not infertility.	☒ M ☐ S
Non-Emergency Transportation				
28	$5,977.00	Agree. Procedure code should have denied as non-covered. The root cause is currently under review. BCBSMT will agree to an overpayment of $5,977.00.	Procedural deficiency and overpayment cited. This charge for non-covered transportation	☒ M ☐ S

ESAS Findings Detail Report				
QID	**Under/ Over Paid**	**BCBSMT Response**	**CTI Conclusion**	**Manual or System**
		BCBSMT adjusted on 5/9/24. However, ambulance provider has subsequently sent in medical records and BCBSMT is reviewing for necessity as of 7/30/24.	services should have been denied and is considered an abusive billing practice.	
Hypnosis, Hypnotherapy				
29	$284.85	Agree. Per the group benefits, hypnotherapy is not covered under the medical plan. This service should have denied but it appears the coding was not set correctly. This is currently under review by the coder. BCBSMT will agree to overpayment of $144.37 on DCN XXXXXXXX120X & $140.48 for DCN XXXXXXXX420X. BCBSMT issued manual credit for these claims as of 7/30/24.	Procedural deficiency and overpayment cited. This charge should have been denied. One claim was auto adjudicated, and one claim was manually adjudicated.	☐ M ☒ S
Plan Limitations				
Intense Outpatient Therapy				
19	$0.00	BCBSMT disagrees. However, a pricing comparison and review has been initiated for the Host Plan, based on CTI's findings.	Procedural deficiency identified. BCBSMT should determine why the host plan's allowed fee for this service was $378.00 per unit on some claims and the billed fee of $2,500.00 on others. BCBSMT should investigate why the fee varied for the same services. The potential impact is $10K overall.	☒ M ☐ S
Preventive Services				
With Deductible Applied				
1	($156.82)	Agree. The deductible applied in error. The root cause is currently under investigation. BCBSMT will agree to an underpayment of $156.82. 7 claims were affected by this issue. All have been adjusted to pay full benefits.	Procedural deficiency and underpayment cited. This preventive service was incorrectly applied to the member's deductible.	☐ M ☒ S

Additional Observation

During the ESAS review, our auditor observed the following procedure or situation that may not have caused an error on the sampled claim but may impact future claims or overall quality of service.

Observation	Audit Number
CTI identified a claim for respiratory pathogen testing. This COVID-19 lab service should not have been covered consistent with CMS determinations in which it does not consider multiplex Polymerase Chain Reaction (PCR) respiratory viral panels of six or more pathogens eligible for reimbursement. CPT codes 0115U, 0202U, 0223U, 0225U, 87632, and 87633 should have denied. CTI recognizes this CMS edit as a best practice and potential for upcoding among providers. We recommend the State and BCBSMT discuss this issue to determine whether or not the State would prefer to continue covering this expense or have BCBSMT make adjustments to their system to deny these types of services.	2

RANDOM SAMPLE AUDIT

Objectives

The objectives of our Random Sample Audit were to determine if claims were paid according to plan specifications and the administrative agreement, to measure and benchmark process quality, and to prioritize areas of administrative deficiency for further review and remediation.

Scope

CTI's Random Sample Audit included a stratified random sample of 180 paid or denied claims. The statistical confidence level of the audit sample was 95%, with a 3% margin of error. A copy of the Sample Construction and Weighting Methodology Report for the sample is in Appendix A.

BCBSMT's performance was measured using the following key performance indicators:

- Financial Accuracy
- Accurate Payment
- Accurate Processing

We also measured claim turnaround time, a commonly relied upon performance measure.

Methodology

Our Random Sample Audit ensures a high degree of consistency and is based upon the principles of statistical process control with a management philosophy of continuous quality improvement. Our auditors reviewed each sample claim selected to ensure it conformed to plan specifications, agreements, and negotiated discounts. We recorded our findings in our proprietary audit system.

When applicable, we cited claim payment and processing errors identified by comparing the way a selected claim was paid and the information BCBSMT had available at the time the transaction was processed**. It is important to note that even if the sampled claim was subsequently corrected prior to CTI's audit, we have still cited the error so you can discuss how to reduce errors and re-work in the future with your administrator.**

CTI communicated with BCBSMT in writing via system-generated response forms regarding any errors or observations. We sent BCBSMT a preliminary report for its review and written response. We considered BCBSMT's written response, as found in Appendix B, when producing our final reports.

Findings

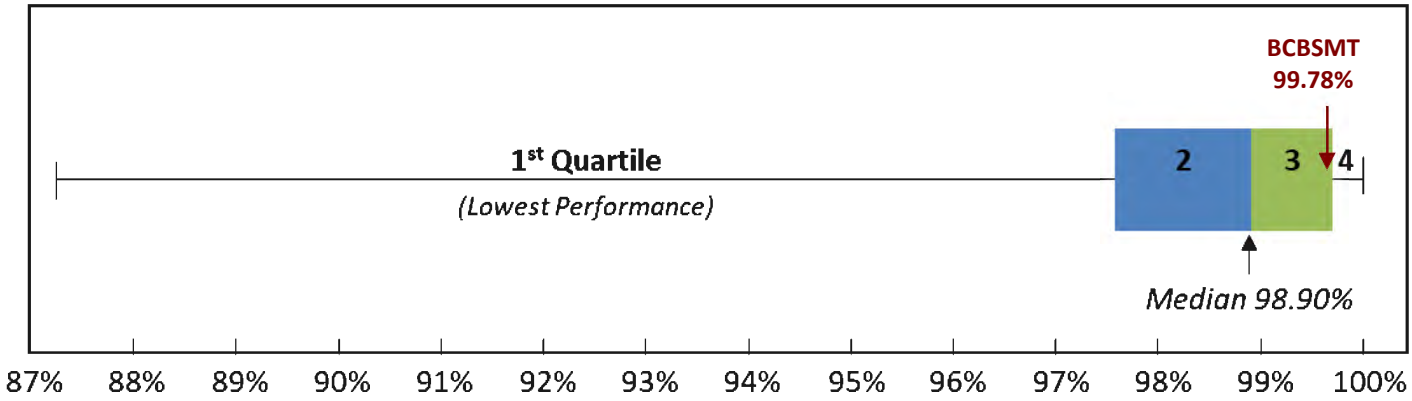
The following box and whiskers charts demonstrate BCBSMT's performance as compared to the last 100 medical audits performed by CTI. The fourth quartile represents the 25 highest performing plans, and the first quartile represents the lowest 25. The Median is the point at which 50 plans audited were above, and 50 plans were below.

Financial Accuracy

CTI defines Financial Accuracy as the total correct claim payments made compared to the total dollars of correct claim payments that should have been made for the audit sample.

The claims sampled and reviewed revealed $7,840.00 in underpayments and no overpayments, for a combined variance of $7,840.00. The correct payment total for the claims in the audit sample should have been $1,660,261.55.

The weighted Financial Accuracy rate was 99.78%.

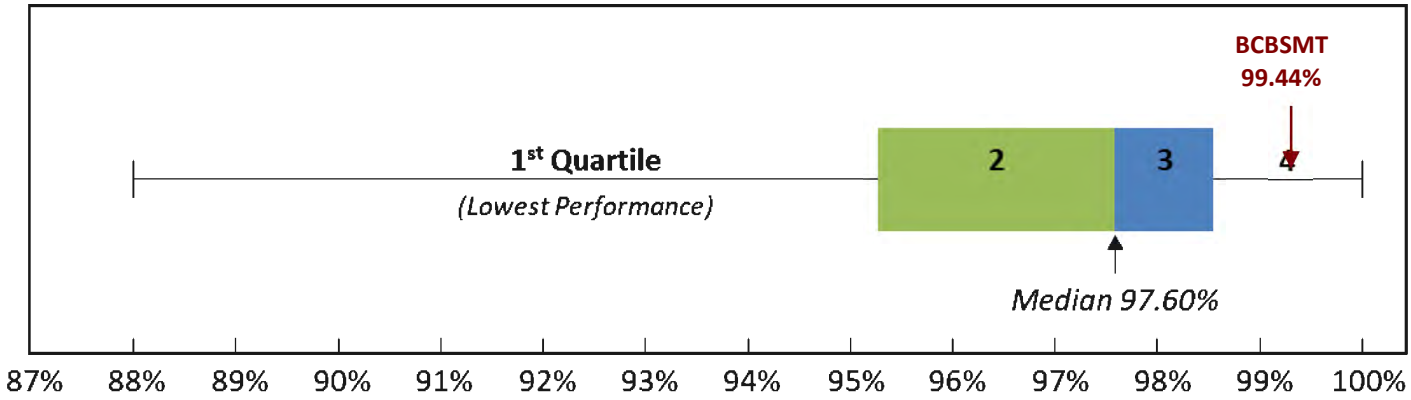


Accurate Payment Frequency

CTI defines Accurate Payment Frequency as the number of claims paid correctly compared to the total number of claims paid for the audit sample.

The audit sample revealed 1 incorrectly paid claims and 179 correctly paid claims. Note CTI only uses adequately documented claims for this calculation.

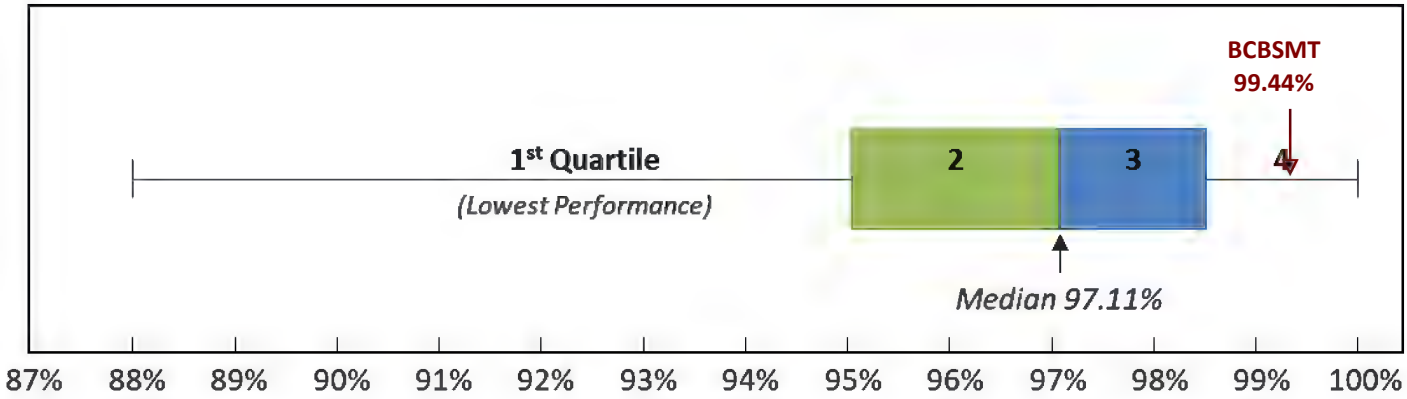
Total Claims	Incorrectly Paid Claims		Frequency
	Underpaid	Overpaid	
180	1	0	99.44%



Accurate Processing Frequency

CTI defines Accurate Processing Frequency as the number of claims processed without errors compared to the total number of claims processed in the audit sample. When a claim had errors that applied in more than one category, it was counted only once as a single incorrect claim for this measure.

Correctly Processed Claims	Incorrectly Processed Claims		Frequency
	System	Manual	
179	0	1	99.44%



Random Sample Findings Detail Report				
Audit No.	**Under/ Over Paid**	**BCBSMT Response**	**CTI Conclusion**	**Manual or System**
PPO Discount Amount				
1006	($7,840.00)	Agree. The operator did not enter the mileage of 225 in the units field which caused the claim to underprice. BCBSMT will agree to an underpayment of $7,840. BCBSMT has adjusted the error on 5/7/24.	Procedural deficiency and underpayment identified. An incorrect price was applied to the claim.	☒ M ☐ S

Claim Turnaround

CTI defines Claim Turnaround as the number of calendar days required to process a claim – from the date the claim was received by the administrator to the date a payment, denial, or additional information request was processed – expressed as both the Median and Mean for the audit sample.

Claim administrators commonly measure claim turnaround time in mean days. Median days, however, is a more meaningful measure for administrators to focus on when analyzing claim turnaround because it prevents one or just a few claims with extended turnaround time from distorting the true performance picture.

Median	Mean	+45 Days to Process
3	7	3

Additional Observations

During the Random Sample Audit, our auditor observed the following procedures or situations that may not have caused an error on the sampled claim but may impact future claims or overall quality of service.

Observation	Audit Number
CTI identified potential fraud on the sampled claim as well as on other claims for this member. The licensed clinical social worker billed 90837 CPT codes (60-minute psychotherapy) services during calendar year 2023 with a high volume of weekly treatments. Payments for this member totaled $5,194. CTI reviewed all members that received care from this provider during the audit period and identified a total of $53,800 was billed – of which 98% represented CPT code 90837 (60-minute psychotherapy) in question. We provided BCBSMT a spreadsheet of the analysis and indicated there was credible information showing the possibility of upcoding by this provider from the 90832 (30-minute psychotherapy) and 90834 CPT code (45-minute psychotherapy) to the 90837 CPT code (60-minute psychotherapy), which pays at a higher rate. This is a common scheme used by providers as noted by the National Health Care Anti-Fraud Association (NHCAA). CTI recommends the clinical records for this provider be requested and reviewed by BCBSMT's SIU for possible upcoding and overlapping session times. In addition, we recommend members be interviewed to determine if services were provided and if so, determine if the length of time reported in the clinical records match. BCBSMT Response: BCBSMT SID team reviewed CTI's spreadsheet analysis and provided a summary for CTI's review. The analysis did not show evidence of abuse by this provider. However, BCBSMT's Sales and Account Management team welcomes the opportunity to discuss these results with the State of Montana to determine if another additional investigation is deemed appropriate.	1104
Expenses for speech therapy were correctly denied on the sampled claim. The State's plan recommended review for medical necessity for therapy services over the 30-visit maximum per condition had been met. The claim was reviewed by BCBSMT, and it was determined additional treatment for speech therapy was not medically necessary. The sampled claim denied correctly. However, there were eight claims paid outside of the 30-visit max in error. BCBSTX agreed to an out of sample overpayment error of $624.00. BCBSMT Response: BCBSMT agrees to an out-of-sample overpayment of $624.00. The error was discovered during the audit in March and was due to the operators paying through a workaround that advises to investigate the number of visits and process accordingly. Feedback was provided to all of the operators that paid the claim in error. The claims will not be adjusted as doing so will negatively impact the patient's share.	1157

CONCLUSION

We consider it a privilege to have worked for, and with, your staff and administrator. Our contract offers eight hours of post-audit time to help you develop an implementation plan should the State desire additional assistance in that regard.

Thank you again for choosing CTI.

APPENDIX A – SAMPLE CONSTRUCTION AND WEIGHTING METHODOLOGY

Client: MTBCBS23
Audit Period: January 01, 2023 - December 31, 2023

Claim Universe (as converted)

Stratum		Claim Count	Total Charge Amount	Total Paid Amount
<=500	1	360,294	$134,035,546	$32,468,269
<=10,000	2	23,871	$108,343,140	$39,975,445
>10,000	3	2,310	$76,376,877	$52,044,066
Totals		386,475	$318,755,563	$124,487,779

Audit Stratification

Stratum		Audit Universe (# Claims)	Proportion (Weight by Count)	Sample
<=500	1	360,294	93.23%	60
<=10,000	2	23,871	6.18%	60
>10,000	3	2,310	0.60%	60
Totals		386,475	100.00%	180

Audit Sample Overview

Category	Count	Paid Amount
Claims requested for audit	180	$1,652,421.55
Claims for which records not received	0	$0.00
Claims outside scope of audit	0	$0.00
Claims as entered included in audit sample	180	$1,652,421.55
Audit sample if all claims paid correctly	180	$1,660,261.55
Claims with inadequate documentation	0	$0.00
Total claim payments remaining in audit sample	180	$1,660,261.55

APPENDIX B – ADMINISTRATOR RESPONSE TO DRAFT REPORT

Please note that any additional information submitted to CTI in response to the draft report from the administrator is reviewed, and observations may be removed prior to the final report being published. While a removed observation will not be included in the final report, it may be referenced in the administrator's response that follows.

August 13, 2024

Marie Pollock
Claim Technologies Incorporated (CTI)
100 Court Avenue – Suite 306
Des Moines, IA 50309

RE: Medical Plan Audit and Performance Evaluation – State of Montana

Dear Marie:

Attached is BCBSMT's response to the draft of CTI's audit report regarding the medical plan audit and performance evaluation conducted on behalf of the State of Montana. Excerpts from your report are in black; BCBSMT responses are in blue. It is our request that this response be included in your final report to the State of Montana.

If you have any questions, please contact me at 972.766.2144

Sincerely,

Nicole DaSilva

Nicole DaSilva
Sr. Audit Specialist
Customer Audit
Audit & Performance Services

copy:
Shannon Bernas
Shontelle Mixon

BLUE CROSS AND BLUE SHIELD OF MONTANA RESPONSE TO THE DRAFT AUDIT REPORT

Claim Technologies Incorporated (CTI) on behalf of the State of Montana

Performance Evaluation of Claim Administration Services
For the period 01/01/2023 through 12/31/2023

July 2024

This is BCBSMT's response to Claim Technologies Incorporated (CTI) draft audit report regarding the medical plan audit conducted on behalf of the State of Montana. Excerpts from the Claim Technologies Incorporated (CTI) report are in black text. BCBSMT responses are in blue text.

OPERATIONAL REVIEW

Findings

We observed the following:

- BCBSMT and the State had a performance agreement with guarantees for the categories of Service and Claim, Implementation, Reporting, Account Management, Provider Reimbursement and Multiple of Medicare Discount Guarantee. BCBSMT provided performance reports for 2023 for Claim Quality and Claims Timeliness as well as for Customer Service. In 2023, BCBSMT did not achieve the target performance goal for Provider and Member Satisfaction, with results of 74.0% and 78.5%, respectively. The goal for these measures were 85.0%. Consequently, BCBSMT issued a settlement credit to the State on April 24, 2024. However, due to a calculation error, BCBSMT had to request repayment. Therefore, as of the date of issuance of this report, BCBSMT has not provided the final payment to the State. BCBSMT measured its performance specifically for the State, a best practice in contrast to administrators who report performance at a service center or book of business level. It should be noted that the Multiple of Medicare Discount Guarantee was not completed by the date of the issuance of this report (Due May 31 each year).

  BCBSMT Response: The BCBSMT Sales & Marketing team have thoroughly discussed the results and settlement amounts with the State and are committed to providing the *final* reports as soon as they are available.

- BCBSMT's claim system did not track the date adjustments were identified; it defaulted to the original claim receipt date. As a result, BCBSMT excluded from claim turnaround time calculations and the corresponding performance guarantee.

  BCBSMT Response: Adjustment turnaround time is not tracked due to the various reasons an adjustment could potentially be made (i.e. medical records). BCBSMT does not have a standard turnaround time for adjustments as turnaround time is only tracked on a claim's first pass.

- BCBSMT adopted procedures to conform with the federal No Surprises Act (NSA). Under the NSA, providers were prohibited from balance billing the member if they were paid the Qualifying Payment Amount (QPA). While BCBSMT did not provide their internal procedures for handling this type of claims, they did report nine member appeals for out-of-network services during 2023. Six of the nine were upheld.

  BCBSMT Response: Policy and procedures are proprietary and confidential and cannot be shared externally as our flows are complex processes, policies, and procedures that are mapped to small, hyperlinked flowcharts.

100% ELECTRONIC SCREENING WITH TARGETED SAMPLE ANALYSIS

Findings

Electronic screening of all service lines processed revealed the potential for incorrectly paid claims. After review of the response and additional information provided by the administrator, CTI confirmed the potential for process improvement. Further testing is recommended.

ESAS Findings Detail Report				
QID	**Under/ Over Paid**	**BCBSMT Response**	**CTI Conclusion**	**Manual or System**
Duplicate Payments				
12	$161.55	Agree. Claim was adjusted 5/7/24. **BCBSMT Response:** BCBSMT agrees to a non-financial duplicate error. The sample claim, xxxxxxx720C, was processed under the clinic/group, not the rendering provider in error. As a result, no payment was made as it applied to the member's out of network deductible. The provider then resubmitted the claim. The resubmitted claim, xxxxxxx710X, processed and paid in network because the provider's information was processed accurately. The sample claim was adjusted to deny as a duplicate on 05/07/2024.	Procedural deficiency and overpayment identified. The claims were for the same service. The initial claim billed under the provider group and the second billed under the individual provider of service.	☒ M ☐ S
13	$106.72	Agree. The claims are billed by 2 different providers, upon further review, one provider was not credentialed and sent in a corrected claim to correct the provider's name. Claim was adjusted on 8/6/24. The duplicate claim applied to the member's deductible. Therefore, no financial impact. **BCBSMT Response:** Per the provider, claim xxxxxxx270C is a duplicate to claim xxxxxxx160X. The patient was seen by Anne Fox PT but at the time, she was not credentialed so she performed the services under the supervision of Brittnie Herbst PT. There is no financial error with this duplicate. Claim xxxxxxx270C processed out of network and applied to the deductible. BCBSMT agrees to a non-financial error. Claim xxxxxxx270C was adjusted on 08/06/2024 to deny. No payment was issued; therefore, no refund is due.	Procedural deficiency and overpayment identified. The claims were for the same service. The initial claim processed as out- of-network and the second claim processed as in-network. The identical physical therapy services should not have paid twice on the same day.	☒ M ☐ S
14	$248.07	Agree. This claim was paid as a duplicate in error. BCBSMT has adjusted the claim 5/3/24. **BCBSMT Response:** DCN xxxxxxx780X is a duplicate to sample claim xxxxxxx770X. The sample claim	Procedural deficiency and overpayment cited. The claims were for same service and paid twice.	☒ M ☐ S

ESAS Findings Detail Report				
QID	Under/ Over Paid	BCBSMT Response	CTI Conclusion	Manual or System
		processed on 09/29/2023, prior to processing xxxxxxx780X on 10/13/2023. The sample claim processed accurately. BCBSTX agrees to an out of sample error of $248.07. The error was discovered during the audit in March and was due to the operator paying the duplicate on the out of sample claim in error. Feedback was provided to the operator on 04/24/2024. The out of sample claim was adjusted to deny and return the funds to the group on 05/03/2024.		
15	$300.00	Agree. Claim was adjusted on 8/6/24. The impact of error was $200, based on pricing. **BCBSMT Response:** BCBSMT agrees to a $200.00 overpayment on claim xxxxxxx790C. The claim was billed with two (2) different provider numbers; however, the claim processed under one (1) provider number in error. The claim was adjusted on 08/06/2024 and a refund in the amount of $200.00 was initiated.	Procedural deficiency and overpayment identified. The claims were for identical services and should not have been allowed twice on the same day.	☒ M ☐ S
16	$0.00	Agree. The claims were billed with 2 different performing provider numbers providing the appearance that these are separate claims so the duplicate paid in error. After review, the provider originally billed with the clinic as the performing provider and then submitted the claim with the actual performing provider. The original (dcn XXXXXXXXX020C) is the incorrect claim and should be denied as a duplicate. This claim paid out of net and completely to the deductible. BCBSMT will agree to a $0 non-financial error. BCBSMT adjusted 5/7/24. **BCBSMT Response:** Upon further review, BCBSMT agrees to a non-financial duplicate error. The sample claim, xxxxxxx020C, was processed under the clinic/group, not the rendering provider in error. As a result, no payment was made as it applied to the member's out of network deductible. The provider then resubmitted the claim. The resubmitted claim, xxxxxxx330X, processed and paid in network because the provider's information was processed accurately. The sample claim was adjusted to deny as a duplicate on 05/07/2024.	Procedural deficiency cited. The claims were for same service. The initial claim billed under the provider group and the second was billed under the individual provider of service.	☐ M ☒ S

ESAS Findings Detail Report				
QID	Under/ Over Paid	BCBSMT Response	CTI Conclusion	Manual or System
Plan Exclusions				
Dental, Extractions Other Impactions				
22	$1,044.26	Agree. The claims receive a prompt that advises them to review and determine if the services performed are covered. The operator allowed the claim in error. State of Montana does not cover the removal of complete bony teeth. BCBSMT will agree to an overpayment of $1,044.26. The claim should not have been allowed. BCBSMT is processing manual credit to the State as of 7/30/24. **BCBSMT Response:** BCBSMT agrees to an overpayment of $1,044.26. The error was discovered during the audit in March and was due the operator paying through a workaround that requires a review of dental services for coverage. The group does not cover the removal of impacted teeth. Feedback was provided to the operator on 04/25/24. The claim has not been adjusted as doing so would negatively impact the patient's share.	Procedural deficiency and overpayment cited. This claim should have been denied.	☒ M ☐ S
Dental, Unlisted Surgical Procedure				
23	$5,582.14	Agree. A workaround stops claim for review of dental services billed. To determine eligibility. This code should have been reviewed for a description. BCBSMT has called the provider for a description of the service and will respond as soon as it is available. BCBSMT has issued a credit to the State on 5/9/24. **BCBSMT Response:** BCBSMT agrees to an overpayment of $5,582.14. The error was discovered during the audit in March and was due to the operator allowing dental services under the medical plan without review. Dental services in a facility setting with anesthesia require medical records to determine if the services are medically necessary for medical benefits. The claim was adjusted to deny for medical records, funds in the amount of $5,582.14 were returned to the group and feedback was provided to the operator on 05/09/2024. Medical records were received and are currently under medical necessity review.	Procedural deficiency and overpayment identified. This claim should have been denied.	☒ M ☐ S
Infertility Treatment				
26	$90.00	Agree. BCBSMT will issue a credit for the member's claim history that was affected by this issue $102.47. **BCBSMT Response:** BCBSMT agrees to an in sample overpayment of $90.00 and an out of sample overpayment of $12.47. The error was caused by the providers billing an inconsistent diagnosis from the surgery claim on file, as a result the services were	Procedural deficiency and overpayment identified. Per page 31 of the plan booklet, charges related to the reversal of an elective sterilization are not covered. This claim was for anesthesia related to the reversal of an elective sterilization and not infertility.	☒ M ☐ S

ESAS Findings Detail Report				
QID	Under/ Over Paid	BCBSMT Response	CTI Conclusion	Manual or System
		allowed. The claims will not be adjusted as doing so will negatively impact the patient's share.		
Non-Emergency Transportation				
28	$5,977.00	Agree. Procedure code should have denied as non-covered. The root cause is currently under review. BCBSMT will agree to an overpayment of $5,977.00. BCBSMT adjusted on 5/9/24. However, ambulance provider has subsequently sent in medical records and BCBSMT is reviewing for necessity as of 7/30/24. **BCBSMT Response:** BCBSMT agrees to an overpayment of $5,977.00. The error was discovered during the audit in March and was due a non-emergency transport service being allowed in error. The claim received a prompt that overrode the prompt to review this service for medical necessity. Impact report results reflect this is the only claim that billed procedure code A0888. The requested medical records have been reviewed and A0888 has been deemed not medically necessary. A refund in the amount of $5,977.00 was initiated on 05/09/2024.	Procedural deficiency and overpayment cited. This charge for non-covered have been denied.	☒ M ☐ S
Hypnosis, Hypnotherapy				
29	$284.85	Agree. Per the group benefits, hypnotherapy is not covered under the medical plan. This service should have denied but it appears the coding was not set correctly. This is currently under review by the coder. BCBSMT will agree to an overpayment of $144.37 on dcn XXXXXXXX120X & $140.48 for dcn XXXXXXXX420X. BCBSMT issued manual credit for these claims as of 7/30/24. **BCBSMT Response:** BCBSMT agrees to an overpayment of $284.85. The error was discovered during the audit in March and was due to incorrect coding that allowed hypnotherapy in error. As of 05/01/24, an indicator was added to deny hypnotherapy as a not corporately covered procedure. An impact report determined this member was the only one impacted by this error. The claim has not been adjusted as doing so would negatively impact the patient's share.	Procedural deficiency and overpayment cited. This charge should have been denied. One claim was auto adjudicated, and one claim was manually adjudicated.	☐ M ☒ S
Plan Limitations				
Intense Outpatient Therapy				
19	$0.00	BCBSMT disagrees. However, a pricing comparison and review has been initiated for the Host Plan, based on CTI's findings. **BCBSMT Response:** Upon further review, BCBSMT continues to disagree as both claims allowed correctly based on the pricing supplied by the Host Plan, Blue	Procedural deficiency identified. BCBSMT should determine why the host plan's allowed fee for this service was $378.00 per unit on some claims and the billed fee of $2,500.00 on others. We	☒ M ☐ S

ESAS Findings Detail Report				
QID	Under/ Over Paid	BCBSMT Response	CTI Conclusion	Manual or System
		Cross of CA. However, per CTI's request, BCBSMT has requested price comparison verification from the Host Plan based on two (2) separate claims billing the same service with different allowances.	believe BCBSMT should investigate why the varying fees for the same services.	
Preventive Services				
With Deductible Applied				
1	($156.82)	Agree. The deductible applied in error. The root cause is currently under investigation. BCBSMT will agree to an underpayment of $156.82. 7 claims were affected by this issue. All have been adjusted to pay full benefits. **BCBSMT Response:** BCBSMT agrees to an underpayment of $156.82. The sample claim initially applied incorrect logic for an Affordable Care Act (ACA) service resulting in the deductible applying in error. A workaround will be implemented on this service for the State of Montana to prevent this error on future claims. An impact report was pulled and a total of seven (7) claims were identified and adjusted to pay the additional funds on 07/24/2024.	Procedural deficiency and underpayment cited. This preventive service was incorrectly applied to the member's deductible.	☐ M ☒ S

Additional Observations

During the ESAS review, our auditor observed the following procedure or situation that may not have caused an error on the sampled claim but may impact future claims or overall quality of service.

Observation	Audit Number
CTI identified a claim for respiratory pathogen testing. This COVID-19 lab service should not have been covered consistent with CMS determinations in which it does not consider multiplex Polymerase Chain Reaction (PCR) respiratory viral panels of six or more pathogens eligible for reimbursement. CPT codes 0115U, 0202U, 0223U, 0225U, 87632, and 87633 should have denied. CTI recognizes this CMS edit as a best practice and potential for upcoding among providers. We recommend the State and BCBSMT discuss this issue to determine whether or not the State would prefer to continue covering this expense or have BCBSMT make adjustments to their system to deny these types of services. **BCBSMT Response:** BCBSMT maintains its response that the service allowed correctly. There are no other services billed on this date of service so procedure 0202U is payable.	2

RANDOM SAMPLE AUDIT

Findings

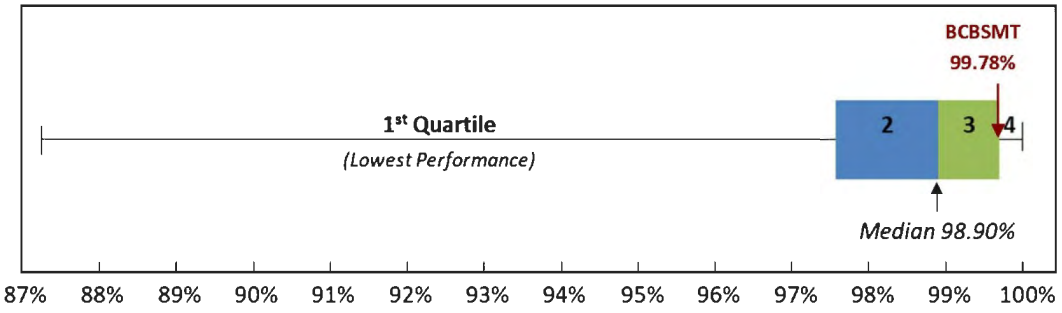
The following box and whiskers charts demonstrate BCBSMT's performance as compared to the last 100 medical audits performed by CTI. The fourth quartile represents the 25 highest performing plans, and the first quartile represents the lowest 25. The Median is the point at which 50 plans audited were above, and 50 plans were below.

Financial Accuracy

CTI defines Financial Accuracy as the total correct claim payments made compared to the total dollars of correct claim payments that should have been made for the audit sample.

The claims sampled and reviewed revealed $7,840.00 in underpayments and no overpayments, for a combined variance of $7,840.00. The correct payment total for the adequately documented claims in the audit sample should have been $1,660,261.55.

The weighted Financial Accuracy rate was 99.78%.

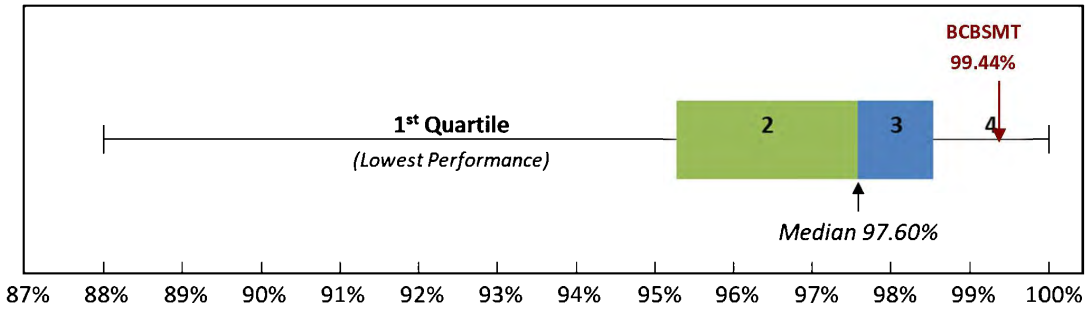


BCBSMT Response: Based upon one (1) agreed error with an underpayment amount of $7,840.00, BCBSMT calculates the weighted Financial Accuracy rate at 99.79%.

Accurate Payment Frequency
CTI defines Accurate Payment Frequency as the number of claims paid correctly compared to the total number of claims paid for the audit sample.

The audit sample revealed 1 incorrectly paid claims and 179 correctly paid claims. Note CTI only uses adequately documented claims for this calculation.

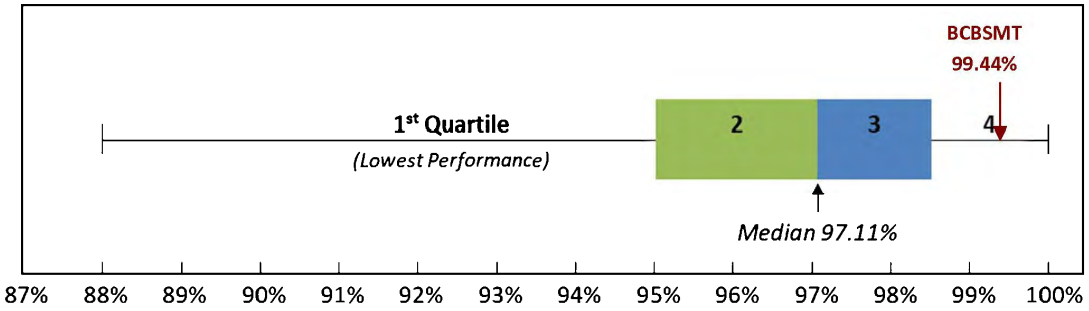
Total Claims	Incorrectly Paid Claims		Frequency
	Underpaid	Overpaid	
180	1	0	99.44%



BCBSMT Response: Based upon one (1) agreed error with an underpayment amount of $7,840.00, BCBSMT calculates the Accurate Payment Frequency rate at 99.99%.

Accurate Processing Frequency
CTI defines Accurate Processing Frequency as the number of claims processed without errors compared to the total number of claims processed in the audit sample. When a claim had errors that applied in more than one category, it was counted only once as a single incorrect claim for this measure.

Correctly Processed Claims	Incorrectly Processed Claims		Frequency
	System	Manual	
179	0	1	99.44%



BCBSMT Response: Based upon one (1) agreed error with an underpayment amount of $7,840.00, BCBSMT calculates the Accurate Processing Frequency rate at 99.99%.

Random Sample Findings Detail Report				
Audit No.	**Under/ Over Paid**	**BCBSMT Response**	**CTI Conclusion**	**Manual or System**
PPO Discount Amount				
1006	($7,840.00)	Agree. The operator did not enter the mileage of 225 in the units field which caused the claim to underprice. BCBSMT will agree to an underpayment of $7,840. BCBSMT has adjusted the error on 5/7/24. **BCBSMT Response:** BCBSMT agrees to an underpayment of $7,840.00. The error was discovered during the audit in March and was due to the operator entering the incorrect mileage. When the operator was prompted, they entered 1 mile and should have entered 225 miles. Feedback was provided to the operator on 04/24/2024. The claim was adjusted on 05/07/24 to pay the additional funds.	Procedural deficiency and underpayment remain. An incorrect price was applied to the claim.	☒ M ☐ S

Additional Observations

During the Random Sample Audit, our auditor observed the following procedures or situations that may not have caused an error on the sampled claim but may impact future claims or overall quality of service.

Observation	Audit Number
CTI has identified potential fraud on the sampled claims as well as on other claims for this member. The licensed clinical social worker was billing 90837 CPT codes (60-minute psychotherapy) services during calendar year 2023 with a high volume of weekly treatments. Payments for this member totaled were $5,194. CTI reviewed all members that received care from this provider during the audit period and identified that $53,800 was billed – of which 98% represented the 90837 CPT code (60- minute psychotherapy) in question. We provided BCBSMT a spreadsheet of the analysis and indicated there is credible information showing the possibility of upcoding by this provider from the 90832 (30-minute psychotherapy) and 90834 CPT code (45-minute psychotherapy) to the 90837 CPT code (60-minute psychotherapy), which pays at a higher rate. This is a common scheme used by providers as noted by the National Health Care Anti- Fraud Association (NHCAA). CTI recommends the clinical records for this provider be requested and reviewed by BCBSMT's SIU for possible upcoding and overlapping session times. In addition, CTI recommends that members be interviewed to determine that services were provided and if so, determine if the length of time reported in the clinical records match. **BCBSMT Response:** BCBSMT SID team reviewed CTI's spreadsheet analysis and provided the attached summary of their results. BCBSMT's Sales and Account Management team welcomes the opportunity to discuss these results with the State of Montana to determine if another additional investigation is deemed appropriate.	1104

Observation	Audit Number
Expenses for speech therapy were correctly denied on sample claim. The State of Montana plan recommends a review for medical necessity of therapy services over the 30-visit maximum per condition has been met. The claim was reviewed by BCBSMT, and it was determined additional treatment for speech therapy was not medically necessary. The sample claim denied correctly. However, there were eight claims that paid outside of the 30-visit max in error. BCBSMT will agree to an out of sample overpayment error of $624.00. **BCBSMT Response:** BCBSMT agrees to an out-of-sample overpayment of $624.00. The error was discovered during the audit in March and was due to the operators paying through a workaround that advises to investigate the number of visits and process accordingly. Feedback was provided to all of the operators that paid the claim in error. The claims will not be adjusted as doing so will negatively impact the patient's share.	1157

This document has been prepared in good faith on the basis of information provided to Claim Technologies Incorporated, without any independent verification. If the data, information, and observations received are inaccurate or incomplete, our review, analysis, and conclusions may likewise be inaccurate or incomplete. Our conclusions and recommendations are developed after careful analysis and reflect our best professional judgment.

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CLAIM TECHNOLOGIES INCORPORATED

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Cindy Jorgenson
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Miki Cestnik

July 2024

The Legislative Audit Committee
of the Montana State Legislature:

Enclosed is the report on the claim audit of the state of Montana prescription benefits plan administered by Navitus Health for the calendar years 2022 and 2023.

The audit was conducted by Claim Technologies Incorporated (CTI), part of Brown & Brown, under a contract between the firm and our office. CTI subcontracts with PillarRx Consulting for the pharmacy benefits audit work. The comments and recommendations contained in this report represent the views of the firm and not necessarily the Legislative Auditor.

The agency's written response to the report recommendations is included in the back of each report.

Respectfully submitted,

/s/ Angus Maciver

Angus Maciver
Legislative Auditor

23C-09

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Prescription Benefit Management Audit

EXECUTIVE SUMMARY

The State of Montana

Audit Period

January 1, 2022 – December 31, 2023

Presented to

The State of Montana

September 2024

Proprietary and Confidential

Prepared by

PillarRx Consulting

Subcontractor to

CLAIM TECHNOLOGIES INCORPORATED

PART OF THE BROWN & BROWN TEAM

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INTRODUCTION

This ***Executive Summary*** presents findings and recommendations the PillarRx Consulting, LLC's (PillarRx) audit team has drawn from its Prescription Benefit Management Audit of Navitus Health Solutions LLC's (Navitus) administration of the State of Montana (the State) pharmacy plan. The information these findings and recommendations are based upon is detailed in the ***Specific Findings Report***.

These audit findings are based on data and information the State, as the plan sponsor, and Navitus, as the Pharmacy Benefit Manager (PBM) provided to PillarRx, and their validity relies upon the accuracy and completeness of that information.

The audit was planned and performed to obtain a reasonable assurance prescription drug claims were adjudicated according to the terms of the contract between Navitus and the State as well as the approved benefit descriptions (summary plan descriptions, plan documents, or other communications).

PillarRx is a firm specializing in audit and control of pharmacy benefit plan administration. The comments made by PillarRx in this report and the ***Specific Findings Report*** relate narrowly and specifically, to the overall efficacy of Navitus' policies, processes, and systems relative to the State paid claims during the audit period.

OBJECTIVES AND SCOPE

Objectives

The objectives of the PillarRx audit of Navitus' pharmacy benefit management were to:

- verify that claims were processed in accordance with the pricing terms specified in the contract;
- verify that claims adjudicated according to plan provisions;
- validate J-Code (codes used by hospitals, health care providers, and managed care organizations to identify injectable drugs and oral immunosuppressive medications) analysis of medical benefits, retail pharmacy network, mail order, and specialty programs.

Scope

PillarRx's audit encompassed the contracts in force and the pharmacy benefit claims administered by Navitus for the audit period of January 1, 2022 through December 31, 2023 for the commercial line of business and the State 's Employer Group Waiver Program (EGWP). The State's population of claims and the total net plan paid (total payment less member co-payment) during this period was:

	Number of Prescriptions Paid	Net Plan Paid
Commercial 2022-2023	698,422	$93,892,878.10
EGWP 2022-2023	101,258	$36,983,698.05

The audit included the following four components:

1. Pricing and Fees Audit
2. Reconciliation of Pricing Guarantees
3. Benefit Payment Accuracy Review
4. J-Code Analysis

KEY FINDINGS AND RECOMMENDATIONS

Pricing and Fees Audit

After verification of the electronic claim data provided by Navitus, PillarRx systematically re-priced 100% of prescription drug claims paid during the audit period to determine that:

- Discounts were applied correctly based on the lesser of Maximum Allowable Cost (MAC), Average Wholesale Price (AWP), and Usual and Customary (U&C); and
- Pharmacy dispensing and administrative fees were applied correctly.

Any errors identified in pricing or fees were shared with Navitus; details of the discussion of those errors between PillarRx and Navitus, can be found under separate cover in the ***Specific Findings Report***.

Reconciliation of Pricing Guarantees

Using the terms of the State contract with Navitus, we accumulated all prescription claims by type and distribution method for the period specified in the contract and balanced the total discount savings against the specified minimum discount guarantees. Similarly, all other performance guarantees were mapped against the actual prescription claims as adjudicated during the prescribed contract periods for performance guarantees. This reconciliation included the following contractual guarantees:

- AWP discounts applied for all drugs against third party pricing sources.
- MAC allowance for generic;
- Specialty drug allowance; and
- Dispensing fees.

Findings and Recommendations

The following tables demonstrate our findings relative to pricing guarantees.

Note: *In the following chart, a* ***negative*** *variance indicates a higher than contracted dispensing fee collected. A* ***positive*** *variance indicates a lower than contracted dispensing fee collected.*

Commercial Dispensing Fees (01/01/2022 – 12/31/2022)					
Component Description	**Contracted Dispensing Fee**	**Number of Claims**	**Total Actual Dispensing Fee**	**Total Calculated Dispensing Fee**	**Total Overage/ (Shortfall)**
Mail Brand	$0.00	732	$1.60	$0.00	($1.60)
Mail Generic	$0.00	3,050	$0.00	$0.00	$0.00
Retail Brand	$0.66	21,276	$12,943.20	$14,042.16	$1,098.96
Retail Generic	$0.66	121,926	$69,003.48	$80,471.16	$11,467.68
Retail Brand EDS	$0.00	8,092	$230.30	$0.00	($230.30)
Retail Generic EDS	$0.00	62,303	$1,922.69	$0.00	($1,922.69)
Specialty Combined	$0.00	$0.00	$0.00	$0.00	$0.00
				TOTAL	**$10,412.05**

Commercial Dispensing Fees (01/01/2023 – 12/31/2023)					
Component Description	**Contracted Dispensing Fee**	**Number of Claims**	**Total Actual Dispensing Fee**	**Total Calculated Dispensing Fee**	**Total Overage/ (Shortfall)**
Mail Brand	$0.00	555	$0.00	$0.00	$0.00
Mail Generic	$0.00	2,884	$1.25	$0.00	($1.25)
Retail Brand	$0.64	20,532	$13,722.42	$13,140.48	($581.94)
Retail Generic	$0.64	126,561	$76,003.92	$80,999.04	$4,995.12
Retail Brand EDS	$0.00	5,814	$320.50	$0.00	($320.50)
Retail Generic EDS	$0.00	68,029	$5,041.36	$0.00	($5,041.36)
Specialty Combined	$0.00	2,201	$0.00	$0.00	$0.00
				TOTAL	**($949.93)**

EGWP Dispensing Fees (01/01/2022 – 12/31/2022)					
Component Description	Contracted Dispensing Fee	Number of Claims	Total Actual Dispensing Fee	Total Calculated Dispensing Fee	Total Overage/ (Shortfall)
Mail Brand	$0.00	318	$0.00	$0.00	$0.00
Mail Generic	$0.00	2,578	$0.00	$0.00	$0.00
Retail Brand	$0.80	3,153	$2,307.36	$2,522.40	$215.04
Retail Generic	$0.80	18,280	$12,747.02	$14,624.00	$1,849.63
Retail Generic EDS	$0.00	1,627	$66.20	$0.00	($66.20)
Retail Brand EDS	$0.00	18,474	$861.96	$0.00	($861.96)
Specialty Combined	$0.00	587	$0.00	$0.00	$0.00
				TOTAL	**$1,136.51**

EGWP Dispensing Fees (01/01/2023 – 12/31/2023)					
Component Description	Contracted Dispensing Fee	Number of Claims	Total Actual Dispensing Fee	Total Calculated Dispensing Fee	Total Overage/ (Shortfall)
Mail Brand	$0.00	297	$0.00	$0.00	$0.00
Mail Generic	$0.00	2,147	$0.40	$0.00	($0.40)
Retail Brand	$1.15	2,949	$2,688.07	$3,391.35	$703.28
Retail Generic	$1.15	16,585	$13,125.09	$19,072.75	$5,947.66
Retail Generic EDS	$0.00	1,793	$139.29	$0.00	($139.29)
Retail Brand EDS	$0.00	17,806	$1,409.16	$0.00	($1,409.16)
Specialty Combined	$0.00	524	$0.00	$0.00	$0.00
				TOTAL	**$5,102.09**

Commercial Discounts (01/01/2022 – 12/31/2022)							
Component Description	Number of Claims	Contracted Discount Rate	Actual Discount Rate	Contracted Claim Ingredient Cost	Actual Claim Ingredient Cost	Variance Total Overage/ (Shortfall)	
Mail Brand	732	24.00%	23.74%	$635,669.72	$637,852.00	($2,182.28)	<
Mail Generic	3,050	87.70%	90.91%	$146,715.59	$108,390.85	$38,324.74	>
Retail Brand	21,276	19.30%	19.95%	$9,344,728.10	$9,270,018.34	$74,709.76	>
Retail Generic	121,926	85.20%	89.47%	$2,612,233.29	$1,858,207.81	$754,025.48	>
Retail Brand EDS	8,092	22.55%	23.35%	$5,752,580.04	$5,693,003.42	$59,576.62	>
Retail Generic EDS	62,303	87.70%	92.36%	$2,680,445.23	$1,665,595.42	$1,014,849.81	>
Specialty Combined	2,319	22.20%	22.28%	$15,622,091.99	$15,605,555.94	$16,563.05	>
			TOTAL	**$36,794,463.96**	**$34,838,623.78**	**$1,955,840.18**	**>**

Commercial Discounts (01/01/2023 – 12/31/2023)							
Component Description*	Number of Claims	Contracted Discount Rate	Actual Discount Rate	Contracted Claim Ingredient Cost	Actual Claim Ingredient Cost	Variance Total Overage/ (Shortfall)	
Mail Brand	555	24.00%	23.83%	$666,707.39	$668,238.92	($1,531.53)	<
Mail Generic	2,884	89.00%	90.21%	$123,921.78	$110,331.81	$13,589.97	>
Retail Brand	20,532	19.55%	19.97%	$11,593,587.94	$11,533,755.27	$59,832.67	>
Retail Generic	119,739	87.00%	88.05%	$2,428,721.95	$2,232,559.63	$196,126.32	>
Retail Brand EDS	5,814	22.55%	23.24%	$6,161,278.41	$6,106,495.09	$54,788.32	>
Retail Generic EDS	68,029	89.00%	92.58%	$2,602,371.16	$1,755,795.52	$846,575.64	>
Specialty Combined	2,201	21.85%	N/A	$19,963,514.73	$15,117,536.38	$4,845,978.35	>
			TOTAL	**$43,540,103.36**	**$37,527,712.62**	**$6,015,390.74**	**>**

EGWP Discounts (01/01/2022 – 12/31/2022)							
Component Description	Number of Claims	Contracted Discount Rate	Actual Discount Rate	Contracted Claim Ingredient Cost	Actual Claim Ingredient Cost	Variance Total Overage/ (Shortfall)	
Mail Brand	318	24.00%	23.95%	$359,617.41	$359,863.22	($245.81)	<
Mail Generic	2,578	87.70%	92.09%	$108,050.17	$69,466.20	$38,583.97	>
Retail Brand	3,153	18.25%	19.62%	$1,626,716.45	$1,599,500.10	$27,216.45	>
Retail Generic	18,280	83.20%	88.36%	$419,052.88	$290,254.83	$128,798.05	>
Retail Brand EDS	1,627	21.55%	22.91%	$2,090,796.07	$2,054,619.97	$36,176.10	>
Retail Generic EDS	18,474	87.70%	90.81%	$739,989.03	$553,101.55	$186,887.48	>
Specialty Combined	587	23.00%	28.57%	$3,872,802.68	$3,592,609.59	$280,193.09	>
			TOTAL	**$43,540,103.36**	**$37,527,712.62**	**$697,609.34**	**>**

EGWP Discounts (01/01/2023 – 12/31/2023)							
Component Description	Number of Claims	Contracted Discount Rate	Actual Discount Rate	Contracted Claim Ingredient Cost	Actual Claim Ingredient Cost	Variance Total Overage/ (Shortfall)	
Mail Brand	297	24.00%	23.95%	$366,354.86	$366,590.93	($236.07)	<
Mail Generic	2,147	88.00%	92.37%	$86,471.11	$54,954.35	$31,516.76	>
Retail Brand	2,949	18.70%	20.48%	$2,231,314.32	$2,182,462.43	$48,851.89	>
Retail Generic	16,585	84.00%	87.10%	$331,534.88	$267,324.88	$64,210.00	>
Retail Brand EDS	1,793	21.80%	22.74%	$2,392,789.63	$2,364,062.48	$28,727.15	>
Retail Generic EDS	17,806	88.00%	91.48%	$715,487.52	$508,196.73	$207,290.79	>
Specialty Combined	524	23.00%	31.70%	$3,772,631.50	$3,346,613.45	$426,018.05	>
			TOTAL	**$9,896,583.83**	**$9,090,205.25**	**$806,378.58**	**>**

In summary, when aggregating the dispensing fee calculations with the discounts achieved, Navitus self- reported overperformances for both 2022 and 2023 Commercial and EGWP accounts.

The following table includes calculations completed by Pillar Rx and demonstrate the total AWP discounts achieved by Navitus for years 2022 and 2023 for both Commercial and EGWP plans.

	PillarRx Combined Discounts and Dispensing Fee Guarantee Reconciliation (Commercial 2022)	PillarRx Combined Discounts and Dispensing Fee Guarantee Reconciliation (Commercial 2023)
Discounts	$1,955,840.18	$6,015,390.74
Dispensing Fees	$10,412.05	($949.93)
Total Achieved	$1,966,253.23	$6,014,440.81
Total Missed	$0.00	$0.00
Amount Due to Client	**$0.00**	**$0.00**

	PillarRx Combined Discounts and Dispensing Fee Guarantee Reconciliation (EGWP 2022)	PillarRx Combined Discounts and Dispensing Fee Guarantee Reconciliation (EGWP 2023)
Discounts	$697,609.34	$806,378.58
Dispensing Fees	$1,136.51	$5,102.09
Total Achieved	$698,745.85	$811,480.67
Total Missed	$0.00	$0.00
Amount Due to Client	**$0.00**	**$0.00**

Benefit Payment Accuracy Review

PillarRx created an exact model of the benefit plan parameters of the State's pharmacy plan in AccuCAST
and systematically re-adjudicated 100% of paid prescription drugs.

Benefit plan parameters analyzed included, but were not limited to:

- Age and gender
- Copay/coinsurance
- Day supply maximums
- Excluded drugs
- Prior authorizations
- Quantity limits
- Refill limits
- Zero balance claims

Exceptions that were identified, but could not be explained by PillarRx's benefit analysts, were provided to Navitus for explanation. When adequate documentation was provided to support exceptions were adjudicated correctly, AccuCAST was reset to represent the revised plan parameters and the claims were electronically re-adjudicated again to ensure consistency.

Copayments

Copayments represented the dollar amount required to be paid by the member when a prescription drug was purchased. Our observations and conclusions relative to copayment application for both the commercial and EGWP lines of business are shown in the following charts.

Commercial Copays (01/01/2022 – 12/31/2023)				
Total Claims	**Copays per Plan**	**Copays Collected**	**Variance**	**Variance%**
698,422	$24,306,790.71	$24,306,790.71	$0.00	0%

EGWP Copays (01/01/2022 – 12/31/2023)				
Total Claims	**Copays per Plan**	**Copays Collected**	**Variance**	**Variance%**
101,258	$10,026,863.41	$10,026,850.70	($12.70)	0.01%

Navitus was able to provide adequate explanation and documentation for each category of exception, which allowed PillarRx to conclude all copayments were applied correctly.

PillarRx agrees with Navitus' responses that copays adjudicated according to plan design specifications.

Drug Exclusions/Prior Authorizations

Exclusions specify the drugs and products that a plan would not cover unless there was a Prior Authorization (PA) on file. Based on documentation provided by the State, PillarRx created excluded drug and PA drug listings and re-adjudicated the claims for these non-covered and prior authorized medications. The claim data and documentation provided by the State allowed PillarRx to confirm that drug exclusions and prior authorizations were administered correctly.

Administration of Age Rules

Age rules specify that a participant must be within a specific age group for a specific medication to be

covered. The claim data and documentation provided by the State allowed PillarRx to confirm that administration of age rules benefits were administered correctly.

Administration of Quantity Limits

Quantity limits are included in plans to ensure safety and appropriate utilization. Based on the language in the drug coverage documents provided by Navitus, claims are adjudicating within the parameters.

Prescription Drug Event (PDE) Records

PDE files include all transactions covered by the Medicare prescription drug plan for prescription drug plans. PillarRx observed some variances in some of the PDE records and these were provided to Navitus for review. Navitus agreed to the following errors and provided the following responses:

1. One claim – Member was charged a $0.00 copay in error. This claim will be reprocessed and an adjusted PDE will be submitted with a copay of $11.90.
2. Eight claims – Claims had a $0.10 secondary tax that was reported as part of the dispensing fee field in error on the PDE record. The claims will be updated to reflect the secondary tax amount in the appropriate field.
3. Three claims – Processed with an incorrect copay. Navitus did provide an adequate explanation for the incorrect copays, but the responses did not address why the claim and PDE total cost did not match. After additional review, PillarRx was able to determine that the PDE amounts did match what Navitus provided in the responses. No issue.

PillarRx recommends the State work directly with Navitus for additional explanation and ensuring the claim and PDE totals are aligned.

J-Code Analysis

As healthcare continues to evolve with new treatments and cures for complex and chronic diseases, managing treatment protocols and identifying cost-containment strategies is critical. Pharmacy costs are 20-30% of total healthcare spend with specialty drug treatments driving the narrative. While these medications have become life-changing, it is estimated that within the next few years, specialty medications will meet or exceed 55% of overall total pharmacy gross costs and will have the same impact in absolute dollars under the medical benefit.

PillarRx has designed an integrated, systematic approach to analyzing specialty medications paid under the pharmacy and medical benefit which delivers a complete clinical claim review in addition to a comprehensive financial analysis.

PillarRx's analysis will:

1. Identify potential gaps that may exist within the program.
2. Facilitate the recovery of double payments if identified.
3. Assure specialty medications are being dosed and administered appropriately and at an optimal site of care.
4. Build a management framework with your medical vendor to mitigate future specialty drug spend while preserving member experience.

Medical Data Analysis

PillarRx's medical specialty drug analysis tool uses J-Codes as part of the Healthcare Common Procedure Coding System (HCPCS) Level II set of procedure codes. J-Codes are the codes used by the

medical claim payer to price and process a claim, including the drug product and any additional fees that may be associated such as where the drug is administered, the provider professional fee, etc.

Pharmacy Data Analysis
PillarRx's pharmacy specialty drug analysis uses proprietary benchmarks and algorithms. A pharmacy vendor uses national Drug Code (NDC) numbers to pay a drug claim, and additional benchmarks are incorporated into the algorithms to understand dosing and duration to identify both clinical accuracy and potential waste with inefficiencies.

For the State of Montana PillarRx loaded 105,458 medical J-Code transactions and 35,928 pharmacy claims for the audit period. A crosswalk between the medical and pharmacy claim was created by matching the employee ID and social security number along with the relationship code to the subscriber, the gender, and date of birth. Over 1,000 medications were reviewed.

This process resulted in a comprehensive review of 100% of the drug claims under both medical and pharmacy plans, sorted and aligned with key opportunities of savings and overall due diligence of the program.

The following chart represents the specialty drug claims reviewed.

Benefit Channel	Total Gross Claim Cost	Total Plan Cost*	Claim Count
Pharmacy	$62,083,823.30	$51,867,308.43	43,040
Medical	$38,465,270.36	$25,889,668.66	17,811
TOTAL	**$100,549,093.66**	**$77,756,977.09**	**60,851**

**No member cost share included.*

Data analytics provided:

- Financial understanding of the various delivery sites of care under the two benefit channels; a comparative analysis of J-Codes medical versus NDC pharmacy.
- Drug claim payments within the medical benefit, which may have varied in cost based on where the medication was administered to the member, e.g., outpatient, medical office, infusion clinic, home, other or if moved to the pharmacy channel.
- Improved rebate savings opportunities that may have been possible either by moving to a different benefit channel or maximizing existing rebates within the current benefit channel vendor, typically discovered under medical.
- Medical/pharmacy claims overlap and duplication of payment. We looked for any concurrent 30-day period for a medical and prescription claim for the same medication.

Channel Benchmarks and Site of Care

PillarRx then conducted an analysis of the medical and pharmacy claims data to:

- Identify differences in pricing (per unit) under both benefits.
- Identify the most appropriate delivery channel or point of access based on diagnosis/indication of drugs and by route of administration.

This analysis allowed by a high-level clinical review to assure each member received an appropriate drug for an appropriate diagnosis for each medication filled. The review compared all specialty claims

within a member's profile with an implied diagnosis for each medication. Within each implied diagnosis, PillarRx assured all utilization was appropriate by drug. Once confirmed, the next step was to review benefit channels and the specific site of service or care findings.
The parameters used for the findings were as follows:

- Exclude all oncology indications/medications.
- Ensure claim count based on 30-day supply (if filled for 90 days, claim count equals three).
- Include specialty drug medications that were filled at two or more sites of administration.
- Include only specialty drug medications with cost averages greater than or equal to $500.00.
- Exclude if no actual or implied rebate information included with cost information.

The results of PillarRx's analysis, documented in detail in the ***Specific Findings Report***, show opportunities for cost savings based on site of care.

Findings – Optimal Benefit Channel/Site of Administration

PillarRx identified opportunities for potential savings. If the State of Montana chose to direct members to a different channel and/or a different site of care within the same channel. Assuming 100% transition to the most favorable channel, there was a potential savings of approximately $7 million over the two year period.

Two or More Channels or Sites of Care				
Optimal Site of Care	Total Allowed Amount	Sum of Claim Count	Potential Movement Savings	Percent Savings
Home	$4,290,553.05	455	$1,994,997.61	45%
Pharmacy	$1,566,899.09	5,722	$502,014.59	32%
Office	$16,036,509.18	3,574	$4,211,178.11	26%
Campus Outpatient Hospital	$3,552,124.31	928	$860,787.17	24%
Ambulatory Surgical Center	$635,382.34	622	$226,283,61	36%
TOTAL	**$26,081,467.97**	**11,351**	**$7,745,241.09**	**36%**

One Channel or Site of Care

The following reports are based on specialty drugs where only one channel or site of service was identified with no comparison to analyze.

Site of Care		
Optimal Site of Care	Total Allowed Amount	Sum of Claim Count
Emergency Room	$22,434.09	2
End Stage Renal Disease Treatment Facility	$567,272.04	46
Home	$21,148.72	4
Office	$2,445,194.33	35
On-Campus Outpatient Hospital	$548,436.63	61
Pharmacy	$49,368,435.42	7,000
Unknown	$14,782.76	2
TOTAL	**$52,987,703.99**	**7,150**

Rebate Savings Opportunities

As detailed in the Specific Findings Report, PillarRx prepared a comparative analysis between actual medical claims and pharmacy claim data for the same Generic Product Indicator (GPI). This demonstrates the advantage of moving drugs from the medical benefit to the pharmacy benefit.

Assuming a 30-day supply of medications and standard rebate amount of $450.00, approximately $7 million could have been achieved during the audit period.

Duplicative Reimbursement

PillarRx reviewed the States's data to identify any potential duplicative reimbursement circumstances. Our analysis compared the fill date on the pharmacy claim to the incurred date on the medical claim for the same drug. If the difference between those dates was less than 15 days, it was considered potential situation of duplicative reimbursement.

PillarRx identified three different samples of duplication. There were two members with a total of six claims, which required additional review to determine if duplicate therapy truly occurred. PillarRx recommends the State and/or Navitus reach out to the medical providers to confirm whether the provider used their own supply of the medication or whether the claim was billed in error.

This document has been prepared in good faith on the basis of information provided to Claim Technologies Incorporated, without any independent verification. If the data, information, and observations received are inaccurate or incomplete, our review, analysis, and conclusions may likewise be inaccurate or incomplete. Our conclusions and recommendations are developed after careful analysis and reflect our best professional judgment.

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Prescription Benefit Management Audit

SPECIFIC FINDINGS REPORT

The State of Montana

Audit Period

January 1, 2022 – December 31, 2023

Presented to

The State of Montana

September 2024

Prepared by

PillarRx Consulting

Subcontractor to

CLAIM TECHNOLOGIES INCORPORATED

PART OF THE BROWN & BROWN TEAM

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ACRONYMS USED IN THIS REPORT

Acronym	Definition
AWP	Average Wholesale Price
DS	Day Supply
EGWP	Employer Group Waiver Plan
HCPCS	Healthcare Common Procedure Coding System
J-Codes	Procedure Codes for Specialty Medications
MAC	Maximum Allowable Cost
MPA	Member Prior Authorization
NC	Non-Covered
NDC	National Drug Code
NPI	National Provider Identifier
PA	Prior Authorization
PDE	Prescription Drug Event
PBM	Pharmacy Benefit Manager
U&C	Usual and Customary

INTRODUCTION

This Specific Findings Report contains detailed information, findings, and conclusions the PillarRx Consulting, LLC's (PillarRx) audit team has drawn from their Prescription Benefit Management Audit of Navitus Health Solutions LLC's (Navitus) administration of the pharmacy plan managed by the Health Care and Benefits Division within the Montana Department of Administration and subject to the oversight of the State of Montana Legislative Audit Division (the State). The statistics, observations, and findings in this report constitute the basis for the analysis and recommendations presented under separate cover in the Executive Summary. This Specific Findings Report is provided to the State, the plan sponsor, and Navitus, the pharmacy benefit manager (PBM).

The findings in this report are based on data and information Navitus and the State provided to PillarRx and the report's validity relies upon the accuracy and completeness of that information.

The audit was planned and performed to obtain a reasonable assurance that prescription drug claims were adjudicated according to the terms of the contract between Navitus and the State as well as Client approved benefit descriptions (summary plan descriptions, plan documents or other communications).

PillarRx is a firm specializing in audit and control of pharmacy benefit plan administration. The statements made by PillarRx in this report relate narrowly and specifically to the overall efficacy of Navitus's policies, processes, and systems relative to the State's paid claims during the audit period. While performing the audit, PillarRx complied with all confidentiality, non-disclosure, and conflict of interest requirements and did not receive anything of value or any benefit of any kind other than agreed upon audit fees.

Audit Objectives

The objectives of the PillarRx audit of Navitus's pharmacy benefit management were to:

- verify that claims were processed in accordance with the pricing terms specified in the contract;
- verify that claims adjudicated according to plan provisions;
- validate J-Code (codes used by hospitals, health care providers, and managed care organizations to identify injectable drugs and oral immunosuppressive medications) analysis of medical benefits, retail pharmacy network, mail order, and specialty programs.

Audit Scope

PillarRx's audit encompassed the contracts in force and the pharmacy benefit claims administered by Navitus for the audit period of January 1, 2022 through December 31, 2023 for the commercial line of business and the State 's Employer Group Waiver Program (EGWP).The State's population of claims and the total net plan paid (total payment less member co-payment) during this period was:

	Number of Prescriptions Paid	Net Plan Paid
Commercial 2022-2023	698,422	$93,892,878.10
EGWP 2022-2023	101,258	$36,983,698.05

The audit included the following four components:

1. SOC 2 Report Review
2. Pricing and Fees Audit
3. Reconciliation of Pricing Guarantees
4. Benefit Payment Accuracy Review
5. J-Code Analysis

Key findings for each component can be found in the following sections of this report. All work papers and system documentation in support of any finding will be provided to the State upon request.

SOC 2 REPORT REVIEW

Navitus provided a copy of the System and Organization Controls (SOC 2) Type 2 report on the Description and Tests of Operating Effectiveness of the Claims Processing System for Navitus September 1, 2021 to August 31 30, 2022 and September 1, 2022 to August 31, 2023 issued by its external auditor Wipfli, LLP.

Navitus' Associate Director, Compliance & SIU provided a bridge letter indicating there were no material changes in controls through December 31, 2023. The report was issued in accordance with the requirements of the American Institute of Certified Public Accountants (the AICPA).

Wipfli performed various testing procedures against the internal controls identified by Navitus in the following areas:

- Control Environment
- Communication and Information
- Risk Assessment
- Monitoring Activities
- Control Activities
- Logical and Physical Access Controls
- System Operations
- Change Management
- Risk Mitigation

PRICING AND FEES AUDIT

Objective

The Pricing and Fees Audit verified claims were processed in compliance with the discounts and fees specified in Navitus's contract with the State.

Scope

After verification of the electronic claim data provided by Navitus, PillarRx systematically re-priced 100% of prescription drug claims paid during the audit period to determine that:

- Discounts were applied correctly based on the lesser of MAC, Average Wholesale Price (AWP), and Usual and Customary (U&C); and
- Pharmacy dispensing and administrative fees were applied correctly.

Methodology

Contract Document Review

PillarRx requested and received from the State and Navitus all contracts, amendments, formulary drug lists, and reconciliation documents.

Claim Validation

We mapped and validated the raw claim data provided by Navitus to our standard layout. Raw claim data represented the successive pharmacy claim transactions that included both paid and reversed claims and was critical to our understanding of Navitus's processing and adjudication rules. Once mapped, the data was reconciled against control totals and put through a rigorous process referred to at PillarRx as data forensics – or the verification of claim data by assessing appropriate patterns and relationships. The data forensics included comparing the mapped data to the following benchmarks:

- Prior authorizations
- Rejections
- Reversals
- National Provider Identifier (NPI)
- National Drug Code (NDC)

To complete the claim validation, we conducted a conference call with Navitus to verify that:

- Pharmacy benefit claims data provided for this audit was complete and accurate;
- Claims were loaded correctly into the PillarRx system; and
- Claim counts and total paid claim amounts were accurate.

Pricing and Fees Analysis

The analysis of pricing and fees included electronic comparison of the pharmacy reimbursements for all brand, generic and specialty drugs, or products.

The allowance for brand and generic drugs compared the contracted guaranteed reimbursement rate to the ingredient cost of the brand and generic drugs. For this audit of Navitus, the ingredient cost allowance was determined using the Blue Book AWP from the MediSpan Drug Database or the pharmacy's U&C listed on the claim for the date each prescription was dispensed.

PillarRx also verified electronically that dispensing fees for each drug type, distribution channel and service fees (e.g., compound drug service fees) were paid in accordance with Navitus's contract.

Pricing and Fees Audit Findings

Pricing Findings

Navitus applied all adjudication methods for determining the correct allowance for prescriptions drugs by type and distribution method during the audit period. Adjudication methods are defined as the process by which a pharmacy submits prescription claims electronically when filling a prescription to ensure accurate pricing, copayments, and timely payment.

Dispensing Fee Findings

The dispensing fee calculated was the amount contractually agreed upon by the State and Navitus as the amount to be paid by the plan to the pharmacy for dispensing a prescription.

As shown in the following tables, for the commercial line of business for period January 1, 2022 through December 31, 2022, the State was undercharged in dispensing fees. In contrast, for the period January 1, 2023 through December 31, 2023, the State was charged more than the contracted dispensing fee for the commercial line of business. For the EGWP line of business the State was undercharged in dispensing fees for both periods between dates January 1, 2022 and December 31, 2023. Total calculated dispensing fees shown have been rounded to the nearest dollar.

***Note:** In the following chart, a **negative** variance indicates a higher than contracted dispensing fee collected. A **positive** variance indicates a lower than contracted dispensing fee collected.*

Commercial Dispensing Fees (01/01/2022 – 12/31/2022)					
Component Description	**Contracted Dispensing Fee**	**Number of Claims**	**Total Actual Dispensing Fee**	**Total Calculated Dispensing Fee**	**Total Overage/ (Shortfall)**
Mail Brand	$0.00	732	$1.60	$0.00	($1.60)
Mail Generic	$0.00	3,050	$0.00	$0.00	$0.00
Retail Brand	$0.66	21,276	$12,943.20	$14,042.16	$1,098.96
Retail Generic	$0.66	121,926	$69,003.48	$80,471.16	$11,467.68
Retail Brand EDS	$0.00	8,092	$230.30	$0.00	($230.30)
Retail Generic EDS	$0.00	62,303	$1,922.69	$0.00	($1,922.69)
Specialty Combined	$0.00	$0.00	$0.00	$0.00	$0.00
				TOTAL	**$10,412.05**

Commercial Dispensing Fees (01/01/2023 – 12/31/2023)					
Component Description	**Contracted Dispensing Fee**	**Number of Claims**	**Total Actual Dispensing Fee**	**Total Calculated Dispensing Fee**	**Total Overage/ (Shortfall)**
Mail Brand	$0.00	555	$0.00	$0.00	$0.00
Mail Generic	$0.00	2,884	$1.25	$0.00	($1.25)
Retail Brand	$0.64	20,532	$13,722.42	$13,140.48	($581.94)
Retail Generic	$0.64	126,561	$76,003.92	$80,999.04	$4,995.12
Retail Brand EDS	$0.00	5,814	$320.50	$0.00	($320.50)
Retail Generic EDS	$0.00	68,029	$5,041.36	$0.00	($5,041.36)
Specialty Combined	$0.00	2,201	$0.00	$0.00	$0.00
				TOTAL	**($949.93)**

EGWP Dispensing Fees (01/01/2022 – 12/31/2022)					
Component Description	**Contracted Dispensing Fee**	**Number of Claims**	**Total Actual Dispensing Fee**	**Total Calculated Dispensing Fee**	**Total Overage/ (Shortfall)**
Mail Brand	$0.00	318	$0.00	$0.00	$0.00
Mail Generic	$0.00	2,578	$0.00	$0.00	$0.00
Retail Brand	$0.80	3,153	$2,307.36	$2,522.40	$215.04
Retail Generic	$0.80	18,280	$12,774.37	$14,624.00	$1,849.63
Retail Generic EDS	$0.00	1,627	$66.20	$0.00	($66.20)
Retail Brand EDS	$0.00	18,474	$861.96	$0.00	($861.96)
Specialty Combined	$0.00	587	$0.00	$0.00	$0.00
				TOTAL	**$1,136.51**

EGWP Dispensing Fees (01/01/2023 – 12/31/2023)					
Component Description	**Contracted Dispensing Fee**	**Number of Claims**	**Total Actual Dispensing Fee**	**Total Calculated Dispensing Fee**	**Total Overage/ (Shortfall)**
Mail Brand	$0.00	297	$0.00	$0.00	$0.00
Mail Generic	$0.00	2,147	$0.40	$0.40	($0.40)
Retail Brand	$1.15	2,949	$2,688.07	$3,391.35	$703.28
Retail Generic	$1.15	16,585	$13,125.09	$19,072.75	$5,947.66
Retail Generic EDS	$0.00	1,793	$139.29	$0.00	($139.29)
Retail Brand EDS	$0.00	17,806	$1,409.16	$0.00	($1,409.16)
Specialty Combined	$0.00	524	$0.00	$0.00	$0.00
				TOTAL	**$5,102.09**

RECONCILIATION OF PRICING GUARANTEES

Objective

The Reconciliation of Pricing Guarantees determined if the discount savings and other price controls with guaranteed performance levels in Navitus's contract with the State were met, and if not met, that accurate credit or payment was made to the State within the timeframe specified in the contract.

Scope

Using the terms of the State's contract with Navitus, we accumulated all prescription claims by type and distribution method for the period specified in the contract and balanced the total discount savings against the specified minimum discount guarantees. Similarly, all other performance guarantees were mapped against the actual prescription claims as adjudicated during the prescribed contract periods for performance guarantees. This reconciliation included the following contractual guarantees:

- AWP discounts applied for all drugs against third party pricing sources;
- MAC allowance for generic;
- Specialty drug allowance; and
- Dispensing fees.

Methodology

PillarRx used its proprietary AccuCAST® system to electronically compile total discount savings by silo (drug type and distribution method) and compare them to the contract guarantees in the Navitus contract. If Navitus's performance fell short of any of the guarantees, we validated that Navitus recognized the shortfall and credited or paid the difference to the State on a timely basis.

Findings

The following tables demonstrate our findings relative to pricing guarantees. Underperformance indicates the actual discounts obtained were less than guaranteed by the contract. Overperformance indicates the actual discounts obtained exceeded those guarantees by the contract.

Commercial Discounts (01/01/2022 – 12/31/2022)							
Component Description	Number of Claims	Contracted Discount Rate	Actual Discount Rate	Contracted Claim Ingredient Cost	Actual Claim Ingredient Cost	Variance Total Overage/ (Shortfall)	
Mail Brand	732	24.00%	23.74%	$635,669.72	$637,852.00	($2,182.28)	<
Mail Generic	3,050	87.70%	90.91%	$146,715.59	$108,390.85	$38,324.74	>
Retail Brand	21,276	19.30%	19.95%	$9,344,728.10	$9,270,018.34	$74,709.76	>
Retail Generic	121,926	85.20%	89.47%	$2,612,233.29	$1,858,207.81	$754,025.48	>
Retail Brand EDS	8,092	22.55%	23.35%	$5,752,580.04	$5,693,003.42	$59,576.62	>
Retail Generic EDS	62,303	87.70%	92.36%	$2,680,445.23	$1,665,595.42	$1,014,849.81	>
Specialty Combined	2,319	22.20%	22.28%	$15,622,091.99	$15,605,555.94	$16,563.05	>
			TOTAL	**$36,794,463.96**	**$34,838,623.78**	**$1,955,840.18**	**>**

Commercial Discounts (01/01/2023 – 12/31/2023)							
Component Description	Number of Claims	Contracted Discount Rate	Actual Discount Rate	Contracted Claim Ingredient Cost	Actual Claim Ingredient Cost	Variance Total Overage/ (Shortfall)	
Mail Brand	555	24.00%	23.83%	$666,707.39	$668,238.92	($1,531.53)	<
Mail Generic	2,884	89.00%	90.21%	$123,921.78	$110,331.81	$13,589.97	>
Retail Brand	20,532	19.55%	19.97%	$11,593,587.94	$11,533,755.27	$59,832.67	>
Retail Generic	119,739	87.00%	88.05%	$2,428,721.95	$2,232,559.63	$196,126.32	>
Retail Brand EDS	5,814	22.55%	23.24%	$6,161,278.41	$6,106,495.09	$54,788.32	>
Retail Generic EDS	68,029	89.00%	92.58%	$2,602,371.16	$1,755,795.52	$846,575.64	>
Specialty Combined	2,201	21.85%	N/A	$19,963,514.73	$15,117,536.38	$4,845,978.35	>
			TOTAL	**$43,540,103.36**	**$37,527,712.62**	**$6,015,390.74**	**>**

EGWP Discounts (01/01/2022 – 12/31/2022)							
Component Description	Number of Claims	Contracted Discount Rate	Actual Discount Rate	Contracted Claim Ingredient Cost	Actual Claim Ingredient Cost	Variance Total Overage/ (Shortfall)	
Mail Brand	318	24.00%	23.95%	$359,617.41	$359,863.22	($245.81)	<
Mail Generic	2,578	87.70%	92.09%	$108,050.17	$69,466.20	$38,583.97	>
Retail Brand	3,153	18.25%	19.62%	$1,626,716.45	$1,599,500.10	$27,216.45	>
Retail Generic	18,280	83.20%	88.36%	$419,052.88	$290,254.83	$128,798.05	>
Retail Brand EDS	1,627	21.55%	22.91%	$2,090,796.07	$2,054,619.97	$36,176.10	>
Retail Generic EDS	18,474	87.70%	90.81%	$739,989.03	$553,101.55	$186,887.48	>
Specialty Combined	587	23.00%	28.57%	$3,872,802.68	$3,592,609.59	$280,193.09	>
			TOTAL	**$43,540,103.36**	**$37,527,712.62**	**$697,609.34**	**>**

EGWP Discounts (01/01/2023 – 12/31/2023)							
Component Description	Number of Claims	Contracted Discount Rate	Actual Discount Rate	Contracted Claim Ingredient Cost	Actual Claim Ingredient Cost	Variance Total Overage/ (Shortfall)	
Mail Brand	297	24.00%	23.95%	$366,354.86	$366,590.93	($236.07)	<
Mail Generic	2,147	88.00%	92.37%	$86,471.11	$54,954.35	$31,516.76	>
Retail Brand	2,949	18.70%	20.48%	$2,231,314.32	$2,182,462.43	$48,851.89	>
Retail Generic	16,585	84.00%	87.10%	$331,534.88	$267,324.88	$64,210.00	>
Retail Brand EDS	1,793	21.80%	22.74%	$2,392,789.63	$2,364,062.48	$28,727.15	>
Retail Generic EDS	17,806	88.00%	91.48%	$715,487.52	$508,196.73	$207,290.79	>
Specialty Combined	524	23.00%	31.70%	$3,772,631.50	$3,346,613.45	$426,018.05	>
			TOTAL	**$9,896,583.83**	**$9,090,205.25**	**$806,378.58**	**>**

In summary, when aggregating the dispensing fee calculations with the discounts achieved, Navitus self-reported overperformances for both 2022 and 2023 Commercial and EGWP accounts.

The following table includes calculations completed by Pillar Rx and demonstrate the total AWP discounts achieved by Navitus for years 2022 and 2023 for both Commercial and EGWP plans.

	PillarRx Combined Discounts and Dispensing Fee Guarantee Reconciliation (Commercial 2022)	PillarRx Combined Discounts and Dispensing Fee Guarantee Reconciliation (Commercial 2023)
Discounts	$1,955,840.18	$6,015,390.74
Dispensing Fees	$10,412.05	($949.93)
Total Achieved	$1,966,253.23	$6,014,440.81
Total Missed	$0.00	$0.00
Amount Due to Client	$0.00	$0.00

	PillarRx Combined Discounts and Dispensing Fee Guarantee Reconciliation (EGWP 2022)	PillarRx Combined Discounts and Dispensing Fee Guarantee Reconciliation (EGWP 2023)
Discounts	$697,609.34	$806,378.58
Dispensing Fees	$1,136.51	$5,102.09
Total Achieved	$698,745.85	$811,480.67
Total Missed	$0.00	$0.00
Amount Due to Client	$0.00	$0.00

BENEFIT PAYMENT ACCURACY REVIEW

Objective

The objective of the Benefit Payment Accuracy Review was to verify correct adjudication of plan design provisions and quantify potential opportunities for recovery and/or cost savings.

Scope

PillarRx created an exact model of the benefit plan parameters of the State ’s pharmacy plan in AccuCAST and systematically re-adjudicated 100% of paid prescription drugs. Benefit plan parameters analyzed included, but were not limited to:

- Age and gender
- Copay/coinsurance
- Day supply maximums
- Excluded drugs
- Prior authorizations
- Quantity limits
- Refill limits
- Zero balance claims

Exceptions that were identified, but could not be explained by PillarRx’s benefit analysts, were provided to Navitus for explanation. When adequate documentation was provided to support exceptions were adjudicated correctly, AccuCAST was reset to represent the revised plan parameters and the claims were electronically re-adjudicated again to ensure consistency.

Methodology

After receiving the plan documentation from the State and Navitus including copayment and coverage rules and summary plan descriptions and/or plan documents, PillarRx programmed the State ’s plan design in AccuCAST. We have-adjudicated each claim and identified any exceptions. We aggregated the exceptions by category and our benefit analysts reviewed each category. Exceptions that could not be explained were submitted to Navitus for review.

PillarRx provided a sample of 135 claims and 46 prescription drug event (PDE) records to Navitus for review and response. Our audit results were based upon those responses. Navitus’ responses will be made available upon request.

Findings

Copayments

Copayments represented the dollar amount required to be paid by the member when a prescription drug was purchased. Our observations and conclusions relative to copayment application for both the commercial and EGWP lines of business are shown in the following charts.

Commercial Copays (01/01/2022 – 12/31/2023)				
Total Claims	**Copays per Plan**	**Copays Collected**	**Variance**	**Variance Percentage**
698,422	$24,306,790.71	$24,306,790.71	$0.00	0%

EGWP Copays (01/01/2022 – 12/31/2023)				
Total Claims	**Copays per Plan**	**Copays Collected**	**Variance**	**Variance Percentage**
101,258	$10,026,863.41	$10,026,850.70	($12.70)	0.01%

Navitus was able to provide adequate explanation and documentation for each category of exception, which allowed PillarRx to conclude all copayments were applied correctly.

PillarRx agrees with Navitus' responses that copays adjudicated according to plan design specifications.

Drug Exclusions/Prior Authorizations

Exclusions specify the drugs and products that a plan would not cover unless there was a Prior Authorization (PA) on file. Based on documentation provided by the State, PillarRx created excluded drug and PA drug listings and re-adjudicated the claims for these non-covered and prior authorized medications.

The claim data and documentation provided by the State allowed PillarRx to confirm that drug exclusions and prior authorizations were administered correctly.

Administration of Age Rules

Age rules specify that a participant must be within a specific age group for a specific medication to be covered. The claim data and documentation provided by the State allowed PillarRx to confirm that administration of age rules benefits were administered correctly.

Administration of Quantity Limits

Quantity limits are included in plans to ensure safety and appropriate utilization. Based on the language in the drug coverage documents provided by Navitus, claims are adjudicating within the parameters.

Prescription Drug Event Records

PDE files include all transactions covered by the Medicare prescription drug plan for prescription drug plans. PillarRx observed some variances in some of the PDE records and these were provided to Navitus for review. Navitus agreed to the following errors and provided the following responses:

1. One claim – Member was charged a $0 copay in error. This claim will be reprocessed and an adjusted PDE will be submitted with a copay of $11.90.
2. Eight claims – Claims had a $0.10 secondary tax that was reported as part of the dispensing fee field in error on the PDE record. The claims will be updated to reflect the secondary tax amount in the appropriate field.
3. Three claims – Processed with an incorrect copay. Navitus did provide an adequate explanation for the incorrect copays, but the responses did not address why the claim and PDE total cost did not match. After additional review, PillarRx was able to determine that the PDE amounts did match what Navitus provided in the responses. No issue.

PillarRx recommends the State work directly with Navitus for additional explanation and ensuring the claim and PDE totals are aligned.

J-CODE ANALYSIS

Specialty Drugs Medical and Pharmacy Data Analysis

As healthcare continues to evolve with new treatments and cures for complex and chronic diseases, managing treatment protocols and identifying cost-containment strategies is critical. Pharmacy costs are 20-30% of total healthcare spend with specialty drug treatments driving the narrative. While these medications have become life-changing, it is estimated that within the next few years, specialty medications will meet or exceed 55% of overall total pharmacy gross costs and will have the same impact in absolute dollars under the medical benefit.

PillarRx has designed an integrated, systematic approach to analyzing specialty medications paid under the pharmacy and medical benefit which delivers a complete clinical claim review in addition to a comprehensive financial analysis. PillarRx's analysis will:

1. Identify potential gaps that may exist within the program.
2. Facilitate the recovery of double payments if identified.
3. Assure specialty medications are being dosed and administered appropriately and at an optimal site of care.
4. Build a management framework with your medical vendor to mitigate future specialty drug spend while preserving member experience.

Data Forensics – Data Loading and Integration

For the initial set-up, PillarRx performs an extensive Quality Control process when loading the data points from both the pharmacy and medical vendors to assure the data integration is aligned accurately.

Medical Data Analysis

PillarRx's medical specialty drug analysis tool uses J-Codes as part of the Healthcare Common Procedure Coding System (HCPCS) Level II set of procedure codes. J-Codes are the codes used by the medical claim payer to price and process a claim, including the drug product and any additional fees that may be associated such as where the drug is administered, the provider professional fee, etc.

Pharmacy Data Analysis

PillarRx's pharmacy specialty drug analysis uses proprietary benchmarks and algorithms. A pharmacy vendor uses national Drug Code (NDC) numbers to pay a drug claim, and additional benchmarks are incorporated into the algorithms to understand dosing and duration to identify both clinical accuracy and potential waste with inefficiencies.

For the State of Montana PillarRx loaded 105,458 medical J-Code transactions and 35,928 pharmacy claims for the audit period. A crosswalk between the medical and pharmacy claim was created by matching the employee ID and social security number along with the relationship code to the subscriber, the gender, and date of birth. Over 1,000 medications were reviewed.

This process resulted in a comprehensive review of 100% of the drug claims under both medical and pharmacy plans, sorted and aligned with key opportunities of savings and overall due diligence of the program.

The following chart represents the specialty drug claims reviewed.

Benefit Channel	Total Gross Claim Cost	Total Plan Cost *	Claim Count
Pharmacy	**$ 62,083,823.30**	**$ 51,867,308.43**	**43,040**
Medical			
Ambulance - Land	$ 172.17	$ 135.46	3
Ambulatory Surgical Center	$ 7,073.18	$ 5,842.72	10
Emergency Room – Hospital	$ 142,771.06	$ 102,792.97	960
End-Stage Renal Disease Treatment Facility	$ 567,272.04	$ 42,754.60	58
Federally Qualified Health Center	$ 762.76	$ 760.63	5
Home	$ 2,750,665.85	$ 2,554,083.86	661
Inpatient Hospital	$ 1,206.84	$ 840.14	98
Off Campus-Outpatient Hospital	$ 1.25	$ 0.94	1
Office	$ 12,619,713.15	$ 11,058,510.80	7,060
On Campus-Outpatient Hospital	$ 22,070,000.39	$ 11,826,702.83	8,678
Pharmacy	$ 121.00	$ -	1
Rural Health Clinic	$ 598.25	$ 569.65	13
Skilled Nursing Facility	$ 19.00	$ 14.25	1
Unknown	$ 304,512.62	$ 296,614.30	117
Urgent Care Facility	$ 376.32	$ 45.51	144
Walk-in Retail Health Clinic	$ 4.48	$ -	1
Total Medical	**$ 38,465,270.36**	**$ 25,889,668.66**	**17,811**
Grand Total	**$ 100,549,093.66**	**$ 77,756,977.09**	**60,851**

**No member cost share included.*

Data analytics provided:

- Financial understanding of the various delivery sites of care under the two benefit channels; a comparative analysis of J-Codes medical versus NDC pharmacy.
- Drug claim payments within the medical benefit, which may have varied in cost based on where the medication was administered to the member, e.g., outpatient, medical office, infusion clinic, home, other or if moved to the pharmacy channel.
- Improved rebate savings opportunities that may have been possible either by moving to a different benefit channel or maximizing existing rebates within the current benefit channel vendor, typically discovered under medical.
- Medical/pharmacy claims overlap and duplication of payment. We looked for any concurrent 30-day period for a medical and prescription claim for the same medication.

Channel Benchmarks and Site of Care

PillarRx then conducted an analysis of the medical and pharmacy claims data to:

- Identify differences in pricing (per unit) under both benefits.
- Identify the most appropriate delivery channel or point of access based on diagnosis/indication of drugs and by route of administration.

This analysis allowed by a high-level clinical review to assure each member received an appropriate drug for an appropriate diagnosis for each medication filled. The review compared all specialty claims within a member's profile with an implied diagnosis for each medication. Within each implied diagnosis, PillarRx assured all utilization was appropriate by drug. Once confirmed, the next step was to review benefit channels and the specific site of service or care findings.

The parameters used for the findings were as follows:

- Exclude all oncology indications/medications.
- Ensure claim count based on 30-day supply (if filled for 90 days, claim count equals three).
- Include specialty drug medications that were filled at two or more sites of administration.
- Include only specialty drug medications with cost averages greater than or equal to $500.
- Exclude if no actual or implied rebate information included with cost information.

The results of our analysis are included in the following charts. The information is based on the parameters defined above for both benefit channels including site of administration. Within sites of administration there are cost variances due to contractual agreements between organizations such as a payor and medical service provider. The optimal opportunities are sorted accordingly by site of care and channel with the most cost-effective sites highlighted in yellow. The following sites of care have been removed from the comparison, Ambulatory surgical center sites, urgent care facilities, end stage renal facilities, emergency rooms, and other unknown facilities.

Findings – Optimal Benefit Channel/Site of Administration

PillarRx identified opportunities for potential savings. If the State of Montana chose to direct members to a different channel and/or a different site of care within the same channel. Assuming 100% transition to the most favorable channel, there was a potential savings of approximately $7 million over the two year period.

Two or More Channels or Sites of Care				
Optimal Site of Care	**Total Allowed Amount**	**Sum of Claim Count**	**Potential Movement Savings**	**Percent Savings**
Home	$4,290,553.05	455	$1,994,997.61	45%
Pharmacy	$1,566,899.09	5,722	$502,014.59	32%
Office	$16,036,509.18	3,574	$4,211,178.11	26%
Campus Outpatient Hospital	$3,552,124.31	928	$860,787.17	24%
Ambulatory Surgical Center	$635,382.34	622	$226,283,61	36%
TOTAL	**$26,081,467.97**	**11,351**	**$7,745,241.09**	**36%**

A more detailed breakdown of the various channels can be found in Exhibit 1.

One Channel or Site of Care

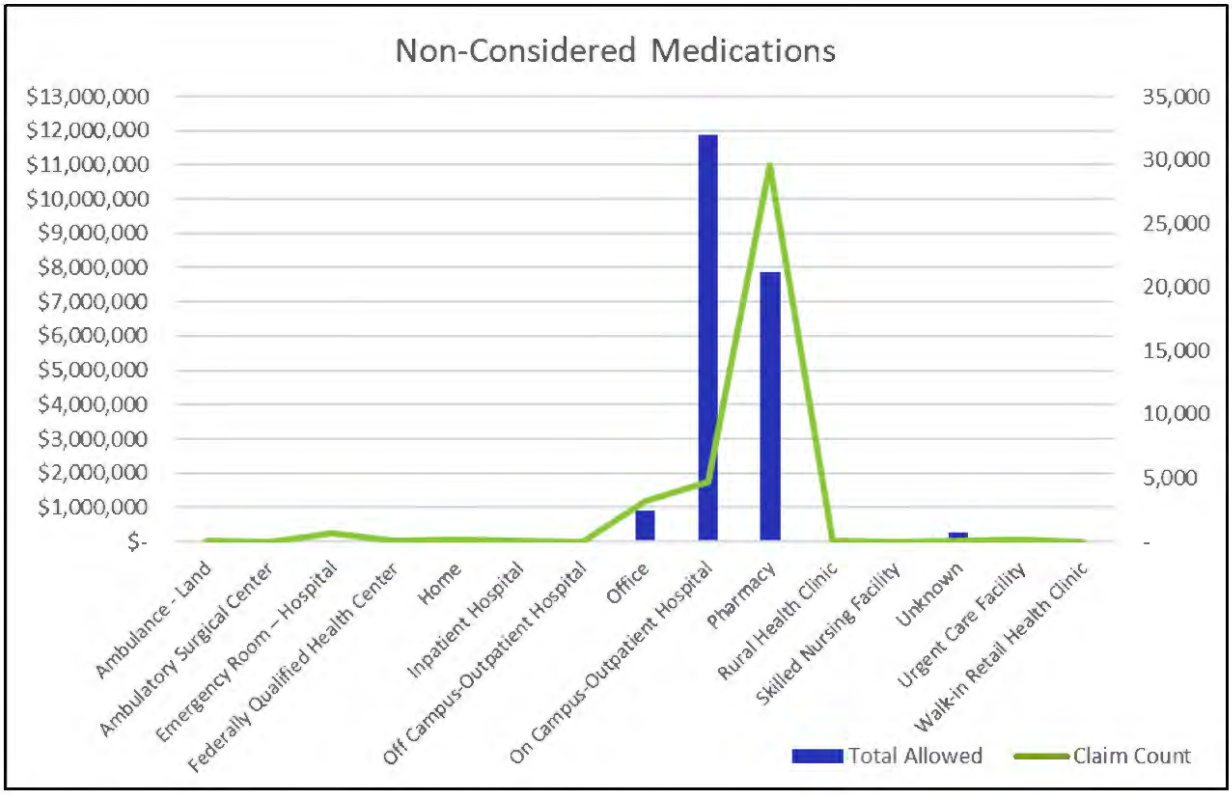
The following reports are based on specialty drugs where only one channel or site of service was identified with no comparison to analyze.

Site of Care		
Optimal Site of Care	**Total Allowed Amount**	**Claim Count**
Emergency Room	$22,434.09	2
End Stage Renal Disease Treatment Facility	$567,272.04	46
Home	$21,148.72	4
Office	$2,445,194.33	35
On-Campus Outpatient Hospital	$548,436.63	61
Pharmacy	$49,368,435.42	7,000
Unknown	$14,782.76	2
TOTAL	**$52,987,703.99**	**7,150**

Details for specific medications filled by site of care can be found in Exhibit 2.

Medications Excluded from Analysis

Some medications fell outside of all parameters. The following chart shows those that did not meet specialty criteria and were therefore not considered for the analysis. Many drugs in this category include oncology and/or lower cost medications.



Details for excluded medications can be found in Exhibit 3.

Rebate Savings Opportunities

PillarRx prepared a comparative analysis between actual medical claims and pharmacy claim data for the same Generic Product Indicator (GPI) to demonstrate the advantage of moving drugs from the medical benefit to the pharmacy benefit. The following parameters were applied:

- For the medical claims we are assuming a 30-day supply to compare to pharmacy claims with a 30-day supply.
- PillarRx uses a standard specialty rebate amount of $450 to calculate the potential rebate per specialty brand claims.
- The total savings calculated assumes a 100% movement of the drug from the medical benefit to the pharmacy benefit channel. An estimated $6.9 million over the entire time period would be the calculated rebate dollars.
- Opportunities to review rebate improvements with current medical vendor is also a potential option versus moving drugs to the pharmacy channel.

Indication	Brand Name ^	Short Description	Medical Claim Count	Average Medical Allowed Amount	Total Allowed Amount	Potential Rebate ($450/ prescription)
Cystic Fibrosis	**TOBRAMYCIN**	Tobramycin	5	$ 4,444.18	$ 22,220.92	$ 2,250.00
Infection	**NOXAFIL**	Posaconazole	11	$ 1,171.30	$ 12,884.32	$ 4,950.00
HIV	**TIVICAY**	Dolutegravir Sodium	7	$ 1,947.54	$ 13,632.81	$ 3,150.00
HIV	**ISENTRESS, ISENTRESS ID**	Raltegravir Potassium	2	$ 1,839.17	$ 3,678.34	$ 900.00
HIV	**PREZISTA**	Darunavir	1	$ 1,478.82	$ 1,478.82	$ 450.00
HIV	**EDURANT, REKAMBYS**	Rilpivirine HCl	1	$ 1,239.66	$ 1,239.66	$ 450.00
HIV	**PREZCOBIX**	Darunavir-Cobicistat	4	$ 2,110.20	$ 8,440.81	$ 1,800.00
HIV	**DESCOVY**	Emtricitabine-Tenofovir Alafenamide Fumarate	4	$ 1,957.78	$ 7,831.12	$ 1,800.00
HIV	**BIKTARVY**	Bictegravir-Emtricitabine-Tenofovir Alafenamid	148	$ 3,521.16	$ 521,132.06	$ 66,600.00
HIV	**SYMFI**	Efavirenz-Lamivudine-Tenofovir Disoproxil Fum	14	$ 1,115.06	$ 15,610.78	$ 6,300.00
HIV	**STRIBILD**	Elvitegravir-Cobicistat-Emtricitabine-Tenofovir A	21	$ 3,514.31	$ 73,800.57	$ 9,450.00
Hepatitis B	**VEMLIDY**	Tenofovir Alafenamide Fumarate	16	$ 1,268.20	$ 20,291.23	$ 7,200.00
Hepatitis C	**MAVYRET**	Glecaprevir-Pibrentasvir	10	$ 12,922.93	$ 129,229.30	$ 4,500.00
COVID-19	**VEKLURY**	Remdesivir	25	$ 1,800.97	$ 45,024.20	$ 11,250.00
Infection	**SIVEXTRO**	Tedizolid Phosphate	3	$ 2,430.49	$ 7,291.47	$ 1,350.00
Immune Deficiency	**GAMMAPLX, PRIVIGEN, OCTAGAM, GAMUNEX**	Immune Globulin (Human) IV	562	$ 3,577.69	$ 2,010,660.15	$ 252,900.00
Immune Deficiency	**HIZENTRA**	Immune Globulin (Human) Subcutaneous	227	$ 3,304.65	$ 750,154.96	$ 102,150.00
Immune Deficiency	**GAMUNEX LIQUID, GAMUNEX-C, GAMMAGARD**	Immune Globulin (Human) IV or Subcutaneous	165	$ 8,070.21	$ 1,331,585.02	$ 74,250.00
Transplant	**CYTOXAN, NEOSAR**	Cyclophosphamide	154	$ 776.65	$ 119,603.50	$ 69,300.00
Endometriosis (F) Oncology (M)	**LUPRON DEPOT, ELIGARD**	Leuprolide Acetate	133	$ 1,350.86	$ 179,663.81	$ 59,850.00
Myelodysplastic syndromes (MDS)	**INQOVI**	Decitabine-Cedazuridine	2	$ 7,614.32	$ 15,228.64	$ 900.00
Muscular Dystrophy	**EMFLAZA**	Deflazacort	37	$ 5,878.97	$ 217,522.07	$ 16,650.00
Endocrine Disorder	**AVEED**	Testosterone Undecanoate	11	$ 723.10	$ 7,954.12	$ 4,950.00
Contraception	**PARAGARD**	Copper (IUD)	52	$ 736.81	$ 38,314.11	$ 23,400.00
Contraception	**KYLEENA, LILETTA, MIRENA, SKYLA**	Levonorgestrel (IUD)	414	$ 1,072.07	$ 443,836.40	$ 186,300.00
Contraception	**IMPLANON, NEXPLANON**	Etonogestrel	137	$ 963.82	$ 132,042.88	$ 61,650.00
Endocrine Disorder	**KORLYM, MIFEPREX**	Mifepristone (Hyperglycemia)	1	$ 26,276.58	$ 26,276.58	$ 450.00
Osteoporosis	**TYMLOS**	Abaloparatide	29	$ 2,327.56	$ 67,499.18	$ 13,050.00
Osteoporosis	**FORTEO**	Teriparatide (Recombinant)	111	$ 3,980.43	$ 441,827.80	$ 49,950.00
Osteoporosis	**PROLIA, XGEVA**	Denosumab	607	$ 1,966.97	$ 1,193,953.53	$ 273,150.00
Osteoporosis	**EVENITY**	Romosozumab-aqqg	3	$ 1,953.66	$ 5,860.99	$ 1,350.00
Infertility	**PREGNYL**	Chorionic Gonadotropin	45	$ 925.40	$ 41,643.13	$ 20,250.00
Growth Deficiency	**GENOTROPIN**	Somatropin	123	$ 3,009.71	$ 370,194.27	$ 55,350.00
Endocrine Disorder	**SOMATULINE**	Lanreotide Acetate	47	$ 10,247.38	$ 481,626.70	$ 21,150.00
Endocrine Disorder	**OCTREOTIDE ACETATE**	Octreotide Acetate	186	$ 9,303.56	$ 1,730,461.84	$ 83,700.00

Indication	Brand Name ^	Short Description	Medical Claim Count	Average Medical Allowed Amount	Total Allowed Amount	Potential Rebate ($450/ prescription)
Thyroid Eye Disease	**TEPEZZA**	Teprotumumab-trbw	19	$ 15,536.65	$ 295,196.44	$ 8,550.00
Endocrine Disorder	**ACTHAR**	Corticotropin	13	$ 42,532.19	$ 552,918.47	$ 5,850.00
Miscellaneous Specialty Condition	**JYNARQUE**	Tolvaptan	56	$ 17,626.52	$ 987,084.91	$ 25,200.00
Enzyme Deficiency	**JAVYGTOR**	Sapropterin Dihydrochloride	5	$ 2,318.99	$ 11,594.97	$ 2,250.00
Miscellaneous Specialty Condition	**VOXZOGO**	Vosoritide	17	$ 27,967.77	$ 475,452.08	$ 7,650.00
Hypercholesterolemia	**REPATHA**	Evolocumab	284	$ 500.32	$ 142,089.49	$ 127,800.00
Pulmonary Hypertension	**ADEMPAS**	Riociguat	49	$ 12,207.88	$ 598,186.35	$ 22,050.00
Pulmonary Hypertension	**LETAIRIS**	Ambrisentan	6	$ 4,272.47	$ 25,634.82	$ 2,700.00
Pulmonary Hypertension	**OPSUMIT**	Macitentan	2	$ 11,763.81	$ 23,527.62	$ 900.00
Miscellaneous Diseases	**VYNDAMAX**	Tafamidis	6	$ 19,742.67	$ 118,456.03	$ 2,700.00
Asthma	**XOLAIR**	Omalizumab	479	$ 2,682.36	$ 1,284,848.74	$ 215,550.00
Asthma & Allergy	**FASENRA**	Benralizumab	125	$ 6,504.93	$ 813,116.18	$ 56,250.00
Asthma	**NUCALA**	Mepolizumab	28	$ 4,672.26	$ 130,823.21	$ 12,600.00
Alpha-1 Deficiency	**ARALAST**	Alpha1-Proteinase Inhibitor (Human)	54	$ 4,372.82	$ 236,132.37	$ 24,300.00
Cystic Fibrosis	**PULMOZYME**	Dornase Alfa	21	$ 4,707.57	$ 98,858.98	$ 9,450.00
Cystic Fibrosis	**TRIKAFTA**	Elexacaftor-Tezacaftor-Ivacaftor	73	$ 24,933.40	$ 1,820,138.02	$ 32,850.00
Pulmonary Hypertension	**ESBRIET**	Pirfenidone	115	$ 5,929.41	$ 681,882.23	$ 51,750.00
Chemotherapy side effect reducer	**EMEND**	Aprepitant	207	$ 755.84	$ 156,458.81	$ 93,150.00
Inflammatory Conditions	**ENTYVIO**	Vedolizumab	188	$ 8,994.99	$ 1,691,057.76	$ 84,600.00
Inflammatory Conditions	**SKYRIZI**	Risankizumab-rzaa (Crohn's)	7	$ 10,089.76	$ 70,628.34	$ 3,150.00
Inflammatory Conditions	**STELARA**	Ustekinumab (IV)	8	$ 6,394.94	$ 51,159.53	$ 3,600.00
Inflammatory Conditions	**CIMZIA**	Certolizumab Pegol	321	$ 5,587.95	$ 1,793,733.38	$ 144,450.00
Inflammatory Conditions	**REMICADE**	Infliximab	89	$ 1,754.17	$ 156,120.77	$ 40,050.00
Miscellaneous Specialty Condition	**XERMELO**	Telotristat Etiprate	3	$ 8,019.32	$ 24,057.96	$ 1,350.00
Miscellaneous Diseases	**INGREZZA**	Valbenazine Tosylate	1	$ 7,374.72	$ 7,374.72	$ 450.00
Multiple Sclerosis (MS)	**GLATOPA, COPAXONE**	Glatiramer Acetate	338	$ 2,533.90	$ 856,458.26	$ 152,100.00
Multiple Sclerosis (MS)	**REBIF, AVONEX**	Interferon Beta-1a	174	$ 8,322.78	$ 1,448,163.32	$ 78,300.00
Multiple Sclerosis (MS)	**BETASERON, EXTAVIA**	Interferon Beta-1b	16	$ 8,563.19	$ 137,011.03	$ 7,200.00
Multiple Sclerosis (MS)	**PLEGRIDY**	Peginterferon Beta-1a	39	$ 7,589.68	$ 295,997.34	$ 17,550.00
Multiple Sclerosis (MS)	**AUBAGIO**	Teriflunomide	240	$ 5,682.38	$ 1,363,771.41	$ 108,000.00
Multiple Sclerosis (MS)	**TYSABRI**	Natalizumab	102	$ 7,148.04	$ 729,099.75	$ 45,900.00
Multiple Sclerosis (MS)	**OCREVUS**	Ocrelizumab	85	$ 37,340.13	$ 3,173,911.34	$ 38,250.00
Multiple Sclerosis (MS)	**VUMERITY**	Diroximel Fumarate	13	$ 7,792.37	$ 101,300.86	$ 5,850.00
Multiple Sclerosis (MS)	**GILENYA**	Fingolimod HCl	198	$ 5,215.62	$ 1,032,692.88	$ 89,100.00
Miscellaneous Specialty Condition	**XYREM**	Sodium Oxybate	7	$ 18,931.50	$ 132,520.50	$ 3,150.00
Miscellaneous Specialty Condition	**ZICONOTIDE**	Ziconotide Acetate	1	$ 9,105.00	$ 9,105.00	$ 450.00
Inflammatory Conditions	**HUMIRA**	Adalimumab	1,979	$ 7,684.85	$ 15,208,322.98	$ 890,550.00
Inflammatory Conditions	**HYRIMOZ**	Adalimumab-adaz	1	$ 1,437.21	$ 1,437.21	$ 450.00
Inflammatory Conditions	**HADLIMA**	Adalimumab-bwwd	1	$ 2,028.22	$ 2,028.22	$ 450.00
Inflammatory Conditions	**SIMPONI**	Golimumab	91	$ 4,112.26	$ 374,215.97	$ 40,950.00
Inflammatory Conditions	**ENBREL**	Etanercept	941	$ 6,398.68	$ 6,021,159.29	$ 423,450.00
Inflammatory Conditions	**ORENCIA**	Abatacept	296	$ 4,967.98	$ 1,470,520.95	$ 133,200.00
Inflammatory Conditions	**KEVZARA**	Sarilumab	35	$ 3,953.29	$ 138,365.13	$ 15,750.00
Inflammatory Conditions	**ACTEMRA**	Tocilizumab	356	$ 3,200.98	$ 1,139,548.91	$ 160,200.00
Inflammatory Conditions	**OLUMIANT**	Baricitinib	41	$ 3,251.32	$ 133,304.12	$ 18,450.00
Inflammatory Conditions	**XELJANZ**	Tofacitinib Citrate	211	$ 5,215.15	$ 1,100,396.70	$ 94,950.00
Inflammatory Conditions	**RINVOQ**	Upadacitinib	271	$ 5,665.48	$ 1,535,345.22	$ 121,950.00
Inflammatory Conditions	**OTEZLA**	Apremilast	447	$ 4,218.11	$ 1,885,493.48	$ 201,150.00
Miscellaneous Specialty Condition	**VYEPTI**	Eptinezumab-jjmr	2	$ 3,502.15	$ 7,004.29	$ 900.00
Miscellaneous Specialty Condition	**VIGADRONE**	Vigabatrin	2	$ 6,570.12	$ 13,140.24	$ 900.00
Miscellaneous Specialty Condition	**EPIDIOLEX**	Cannabidiol	7	$ 3,363.33	$ 23,543.29	$ 3,150.00
Miscellaneous Specialty Condition	**BANZEL**	Rufinamide	13	$ 856.76	$ 11,137.87	$ 5,850.00
Miscellaneous Specialty Condition	**DYSPORT**	AbobotulinumtoxinA	7	$ 702.34	$ 4,916.41	$ 3,150.00
Miscellaneous Specialty Condition	**BOTOX**	OnabotulinumtoxinA	754	$ 840.94	$ 634,066.91	$ 339,300.00
Miscellaneous Specialty Condition	**MYOBLOC**	RimabotulinumtoxinB	10	$ 607.33	$ 6,073.33	$ 4,500.00
Miscellaneous Specialty Condition	**XEOMIN**	IncobotulinumtoxinA	12	$ 1,010.08	$ 12,121.00	$ 5,400.00
Muscular Dystrophy	**RADICAVA**	Edaravone	42	$ 10,384.34	$ 436,142.48	$ 18,900.00
Amyotrophic lateral sclerosis (ALS)	**RELYVRIO**	Sodium Phenylbutyrate-Taursodiol	3	$ 11,030.39	$ 33,091.16	$ 1,350.00
Muscular Atrophy	**ZOLGENSMA**	Onasemnogene Abeparvovec-xioi	1	$ 2,127,500.00	$ 2,127,500.00	$ 450.00
Blood Cell Deficiency	**ARANESP**	Darbepoetin Alfa	176	$ 849.72	$ 149,551.52	$ 79,200.00
Blood Cell Deficiency	**NEUPOGEN, GRANIX, ZARXIO**	Filgrastim	3	$ 985.58	$ 2,956.74	$ 1,350.00
Blood Cell Deficiency	**NIVESTYM**	Filgrastim-aafi	6	$ 949.44	$ 5,696.62	$ 2,700.00
Blood Cell Deficiency	**ZARXIO**	Filgrastim-sndz	4	$ 1,709.57	$ 6,838.29	$ 1,800.00
Blood Cell Deficiency	**NEULASTA**	Pegfilgrastim	76	$ 3,742.46	$ 284,426.92	$ 34,200.00
Blood Cell Deficiency	**NEULASTA, UDENYCA**	Pegfilgrastim-jmdb	5	$ 3,431.77	$ 17,158.87	$ 2,250.00
Blood Cell Deficiency	**MOZOBIL**	Plerixafor	4	$ 3,695.69	$ 14,782.76	$ 1,800.00
Hemophilia	**NOVOEIGHT**	Antihemophilic Factor (Recombinant) (rFVIII)	25	$ 17,431.00	$ 435,775.05	$ 11,250.00
Hemophilia	**ADYNOVATE**	Antihemophilic Factor (Recombinant) Pegylated	55	$ 13,969.19	$ 768,305.21	$ 24,750.00
Hemophilia	**AFSTYLA**	Antihemophilic Factor (Recombinant) Single Cha	3	$ 4,014.57	$ 12,043.72	$ 1,350.00
Hemophilia	**HEMLIBRA**	Emicizumab-kxwh	57	$ 19,681.42	$ 1,121,840.76	$ 25,650.00
Hemophilia	**INTEGRILIN**	Eptifibatide	1	$ 4,935.00	$ 4,935.00	$ 450.00
Thrombolytic	**ACTIVASE**	Alteplase	71	$ 625.16	$ 44,386.06	$ 31,950.00

Indication	Brand Name ^	Short Description	Medical Claim Count	Average Medical Allowed Amount	Total Allowed Amount	Potential Rebate ($450/ prescription)
Hemophilia	**TNKASE**	Tenecteplase	6	$ 8,362.32	$ 50,173.94	$ 2,700.00
Miscellaneous Specialty Condition	**SOLIRIS**	Eculizumab	30	$ 27,397.23	$ 821,916.90	$ 13,500.00
Hereditary Angioedema	**FIRAZYR**	Icatibant Acetate	1	$ 32,898.65	$ 32,898.65	$ 450.00
Ophthalmic Conditions	**OZURDEX**	Dexamethasone (Ophth)	29	$ 739.39	$ 21,442.35	$ 13,050.00
Ophthalmic Conditions	**EYLEA, ZALTRAP**	Aflibercept	549	$ 1,987.75	$ 1,091,274.66	$ 247,050.00
Ophthalmic Conditions	**LUCENTIS**	Ranibizumab	43	$ 1,789.36	$ 76,942.65	$ 19,350.00
Ophthalmic Conditions	**VISUDYNE**	Verteporfin	6	$ 562.10	$ 3,372.60	$ 2,700.00
Inflammatory Conditions	**TREMFYA**	Guselkumab	113	$ 12,498.61	$ 1,412,343.37	$ 50,850.00
Inflammatory Conditions	**TALTZ**	Ixekizumab	327	$ 7,032.86	$ 2,299,745.67	$ 147,150.00
Inflammatory Conditions	**SKYRIZI**	Risankizumab-rzaa	209	$ 18,521.23	$ 3,870,936.12	$ 94,050.00
Inflammatory Conditions	**COSENTYX**	Secukinumab	26	$ 7,336.16	$ 190,740.25	$ 11,700.00
Inflammatory Conditions	**STELARA**	Ustekinumab	365	$ 16,883.81	$ 6,162,589.47	$ 164,250.00
Asthma & Allergy	**DUPIXIENT**	Dupilumab	624	$ 3,567.40	$ 2,226,057.21	$ 280,800.00
Infection	**VALCHLOR**	Mechlorethamine HCl (Topical)	20	$ 5,592.69	$ 111,853.76	$ 9,000.00
Miscellaneous Specialty Condition	**QUTENZA**	Capsaicin & Cleansing Gel	8	$ 3,329.99	$ 26,639.94	$ 3,600.00
Miscellaneous Specialty Condition	**REVIA, VIVITROL**	Naltrexone	19	$ 1,495.89	$ 28,421.91	$ 8,550.00
Miscellaneous Specialty Condition	**XIAFLEX**	Collagenase Clostridium Histolyticum	37	$ 3,291.56	$ 121,787.78	$ 16,650.00
Miscellaneous Specialty Condition	**REZUROCK**	Belumosudil Mesylate	7	$ 17,117.15	$ 119,820.05	$ 3,150.00
Transplant	**AFINITOR**	Everolimus (Immunosuppressant)	28	$ 1,718.23	$ 48,110.31	$ 12,600.00
Transplant	**NULOJIX**	Belatacept	42	$ 1,242.41	$ 52,181.27	$ 18,900.00
Inflammatory Conditions	**BENLYSTA**	Belimumab	138	$ 3,342.40	$ 461,250.90	$ 62,100.00
			Potential Savings (Rebates of $450/Prescription)			$ 6,904,350.00

^ *Italic Brand Names* are listed on medical claims

^ **BOLD Brand Names** are brands associated with drug dispensed

Duplicative Reimbursement

PillarRx reviewed the States's data to identify any potential duplicative reimbursement circumstances. Our analysis compared the fill date on the pharmacy claim to the incurred date on the medical claim for the same drug. If the difference between those dates was less than 15 days, it was considered potential situation of duplicative reimbursement. PillarRx identified three (3) different samples of duplication. There were two members with a total of six claims, which required additional review to determine if duplicate therapy truly occurred. It is recommended that the client reach out to the medical providers to confirm whether the provider used their own supply of the medication or whether the claim was billed in error.

See Exhibit 4 for the duplicate claim details.

APPENDIX – ADMINISTRATOR RESPONSE TO DRAFT REPORT

NAVITUS

July 30, 2024

To Whom it May Concern:

Navitus has reviewed the State of Montana draft audit report for the audit periods of Commercial: January 2022 –December 2022 and January 2023 – December 2023 EGWP: January 2022 – December 2022 and January 2023 – December 2023 and has no comments or updates to the State of MT 2023 SF Draft Report 07.29.2024 version of the report.

EXHIBITS

EXHIBIT 1

Two or more channels/optimal site of care - detailed breakdown of the various channels and which site was the most optimal per medication.

Home

Diagnosis / Indication	Medication	Site of Care	Total Allowed Amount	Sum of Claim Count	Utilizing Members	Average Allowed / Claim	Average Allowed / Utilizing Members
Alpha-1 Deficiency	Alpha1-Proteinase Inhibitor (Human)	Home	$ 147,468.68	40	1	$ 3,686.72	$147,468.68
		On Campus-Outpatient Hospi	$ 88,663.69	12	1	$ 7,388.64	$ 88,663.69
Blood Cell Deficiency	Darbepoetin Alfa	Home	$ 298.14	1	1	$ 298.14	$ 298.14
		Office	$ 5,307.99	9	3	$ 589.78	$ 1,769.33
		On Campus-Outpatient Hospi	$ 143,945.39	101	10	$ 1,425.20	$ 14,394.54
Endocrine Disorder	Octreotide Acetate	Emergency Room – Hospital	$ 802.31	2	2	$ 401.16	$ 401.16
		Home	$ 83.52	1	1	$ 83.52	$ 83.52
		Office	$ 332,303.79	25	2	$13,292.15	$166,151.90
		On Campus-Outpatient Hospi	$ 1,040,285.91	69	8	$15,076.61	$130,035.74
		Pharmacy	$ 259,170.36	53	6	$ 4,890.01	$ 43,195.06
Hemophilia	Antihemophilic Factor (Recombinant) Pegy	Home	$ 557,061.90	40	1	$13,926.55	$557,061.90
		Office	$ 211,243.31	11	1	$19,203.94	$211,243.31
	Emicizumab-kxwh	Home	$ 705,891.16	37	2	$19,078.14	$352,945.58
		Office	$ 415,949.60	17	3	$24,467.62	$138,649.87
Muscular Dystrophy	Edaravone	Home	$ 328,012.12	33	1	$ 9,939.76	$328,012.12
		Pharmacy	$ 54,065.18	4	1	$13,516.30	$ 54,065.18
		Totals	**$ 4,290,553.05**	**455**		**$ 9,429.79**	
		Potential movement savings	**$ 1,944,977.61**				

Pharmacy

Diagnosis / Indication	Medication	Site of Care	Total Allowed Amount	Sum of Claim Count	Utilizing Members	Average Allowed / Claim	Average Allowed / Utilizing Members
Asthma	Mepolizumab	Office	$ 47,801.28	6	2	$ 7,966.88	$ 23,900.64
		On Campus-Outpatient Hospi	$ 12,877.50	1	1	$ 12,877.50	$ 12,877.50
		Pharmacy	$ 70,144.43	20	4	$ 3,507.22	$ 17,536.11
Asthma & Allergy	Benralizumab	Office	$ 165,841.27	29	5	$ 5,718.66	$ 33,168.25
		On Campus-Outpatient Hospi	$ 384,171.91	43	5	$ 8,934.23	$ 76,834.38
		Pharmacy	$ 263,103.00	48	5	$ 5,481.31	$ 52,620.60
Bipolar Disorder	Aripiprazole	Office	$ 10,833.44	4	1	$ 2,708.36	$ 10,833.44
		Pharmacy	$ 72,270.49	3,165	361	$ 22.83	$ 200.20
Chemotherapy side effec	Aprepitant	Office	$ 7,301.02	12	4	$ 608.42	$ 1,825.26
		On Campus-Outpatient Hospi	$ 149,020.21	152	35	$ 980.40	$ 4,257.72
		Pharmacy	$ 137.58	1	1	$ 137.58	$ 137.58
Endocrine Disorder	Testosterone Undecanoate	Office	$ 4,185.00	3	1	$ 1,395.00	$ 4,185.00
		Pharmacy	$ 1,884.56	4	1	$ 471.14	$ 1,884.56
Hemophilia	Desmopressin Acetate	On Campus-Outpatient Hospi	$ 4,078.85	4	4	$ 1,019.71	$ 1,019.71
		Pharmacy	$ 5,835.57	104	18	$ 56.11	$ 324.20
Inflammatory Conditions	Risankizumab-rzaa (Crohn's)	On Campus-Outpatient Hospi	$ 51,440.22	3	1	$ 17,146.74	$ 51,440.22
		Pharmacy	$ 19,188.12	2	1	$ 9,594.06	$ 19,188.12
Miscellaneous Specialty C	Baclofen	Home	$ 481.98	1	1	$ 481.98	$ 481.98
		Office	$ 6,664.32	4	1	$ 1,666.08	$ 6,664.32
		Pharmacy	$ 13,701.32	1,165	237	$ 11.76	$ 57.81
	Naltrexone	Office	$ 15,532.00	10	4	$ 1,553.20	$ 3,883.00
		On Campus-Outpatient Hospi	$ 3,904.31	1	1	$ 3,904.31	$ 3,904.31
		Pharmacy	$ 8,985.60	6	2	$ 1,497.60	$ 4,492.80
Ophthalmic Conditions	Dexamethasone (Ophth)	Ambulatory Surgical Center	$ 1,287.09	3	2	$ 429.03	$ 643.55
		Office	$ 19,572.79	15	3	$ 1,304.85	$ 6,524.26
		On Campus-Outpatient Hospi	$ 494.04	1	1	$ 494.04	$ 494.04
		Pharmacy	$ 926.04	8	5	$ 115.76	$ 185.21
Transplant	Cyclophosphamide	Office	$ 4,100.62	6	2	$ 683.44	$ 2,050.31
		On Campus-Outpatient Hospi	$ 110,840.32	101	15	$ 1,097.43	$ 7,389.35
		Pharmacy	$ 3,908.18	21	3	$ 186.10	$ 1,302.73
		Unknown	$ 754.38	1	1	$ 754.38	$ 754.38
	Tacrolimus	Home	$ 9,664.58	16	2	$ 604.04	$ 4,832.29
		Pharmacy	$ 91,044.22	804	37	$ 113.24	$ 2,460.65
		Unknown	$ 4,922.85	8	1	$ 615.36	$ 4,922.85
		Totals	**$ 1,566,899.09**	**5,772**		**$ 271.47**	
		Potential movement savings	**$ 502,014.59**				

Office

Diagnosis / Indication	Medication	Site of Care	Total Allowed Amount	Sum of Claim Count	Utilizing Members	Average Allowed / Claim	Average Allowed / Utilizing Members
Asthma	Omalizumab	Office	$ 598,488.14	241	19	$ 2,483.35	$ 31,499.38
		On Campus-Outpatient Hospi	$ 209,474.11	53	6	$ 3,952.34	$ 34,912.35
		Pharmacy	$ 476,886.49	170	14	$ 2,805.21	$ 34,063.32
Blood Cell Deficiency	Pegfilgrastim	Office	$ 36,237.82	8	1	$ 4,529.73	$ 36,237.82
		On Campus-Outpatient Hospi	$ 248,189.10	43	8	$ 5,771.84	$ 31,023.64
Contraception	Copper (IUD)	Office	$ 34,425.75	44	43	$ 782.40	$ 800.60
		Pharmacy	$ 3,888.36	4	4	$ 972.09	$ 972.09
	Etonogestrel	Office	$ 121,672.53	117	116	$ 1,039.94	$ 1,048.90
		On Campus-Outpatient Hospi	$ 4,518.41	3	3	$ 1,506.14	$ 1,506.14
		Pharmacy	$ 5,297.91	5	5	$ 1,059.58	$ 1,059.58
		Rural Health Clinic	$ 554.03	1	1	$ 554.03	$ 554.03
Endometriosis (F) Oncolo	Leuprolide Acetate	Office	$ 96,633.35	62	26	$ 1,558.60	$ 3,716.67
		On Campus-Outpatient Hospi	$ 83,030.46	51	18	$ 1,628.05	$ 4,612.80
Immune Deficiency	Immune Globulin (Human) IV	Office	$ 556,294.34	234	9	$ 2,377.33	$ 61,810.48
		On Campus-Outpatient Hospi	$ 1,454,365.81	231	18	$ 6,295.96	$ 80,798.10
	Immune Globulin (Human) IV or Subcutane	Emergency Room – Hospital	$ 19,405.90	2	1	$ 9,702.95	$ 19,405.90
		Office	$ 87,734.53	24	3	$ 3,655.61	$ 29,244.84
		On Campus-Outpatient Hospi	$ 1,137,987.27	108	3	$ 10,536.92	$ 379,329.09
		Pharmacy	$ 105,863.22	24	1	$ 4,410.97	$ 105,863.22
	Immune Globulin (Human) Subcutaneous	Home	$ 595,950.17	115	3	$ 5,182.18	$ 198,650.06
		Office	$ 11,495.62	9	2	$ 1,277.29	$ 5,747.81
		On Campus-Outpatient Hospi	$ 110,559.36	17	7	$ 6,503.49	$ 15,794.19
		Pharmacy	$ 32,149.81	30	1	$ 1,071.66	$ 32,149.81
Inflammatory Conditions	Abatacept	Office	$ 86,505.93	18	3	$ 4,805.89	$ 28,835.31
		On Campus-Outpatient Hospi	$ 194,162.09	41	3	$ 4,735.66	$ 64,720.70
		Pharmacy	$ 932,860.09	182	16	$ 5,125.60	$ 58,303.76
	Belimumab	Office	$ 162,959.90	78	2	$ 2,089.23	$ 81,479.95
		On Campus-Outpatient Hospi	$ 58,858.64	6	1	$ 9,809.77	$ 58,858.64
		Pharmacy	$ 239,432.36	53	4	$ 4,517.59	$ 59,858.09
	Infliximab	Home	$ 2,286.50	1	1	$ 2,286.50	$ 2,286.50
		Office	$ 78,755.90	63	11	$ 1,250.09	$ 7,159.63
		On Campus-Outpatient Hospi	$ 75,078.37	19	6	$ 3,951.49	$ 12,513.06
	Tocilizumab	Office	$ 19,890.01	12	3	$ 1,657.50	$ 6,630.00
		On Campus-Outpatient Hospi	$ 496,704.82	162	7	$ 3,066.08	$ 70,957.83
		Pharmacy	$ 553,434.04	145	15	$ 3,816.79	$ 36,895.60
	Ustekinumab (IV)	Office	$ 39,450.45	7	6	$ 5,635.78	$ 6,575.08
		On Campus-Outpatient Hospi	$ 11,709.08	1	1	$ 11,709.08	$ 11,709.08
	Vedolizumab	Office	$ 783,374.94	95	14	$ 8,246.05	$ 55,955.35
		On Campus-Outpatient Hospi	$ 907,682.82	80	13	$ 11,346.04	$ 69,821.76
Miscellaneous Specialty C	Capsaicin & Cleansing Gel	Office	$ 4,478.54	2	2	$ 2,239.27	$ 2,239.27
		Pharmacy	$ 11,080.70	3	1	$ 3,693.57	$ 11,080.70
Multiple Sclerosis (MS)	Natalizumab	Office	$ 517,970.61	66	4	$ 7,848.04	$ 129,492.65
		On Campus-Outpatient Hospi	$ 211,129.14	25	3	$ 8,445.17	$ 70,376.38
	Ocrelizumab	Home	$ 119,733.48	3	2	$ 39,911.16	$ 59,866.74
		Office	$ 2,056,983.61	60	21	$ 34,283.06	$ 97,951.60
		On Campus-Outpatient Hospi	$ 997,194.25	17	6	$ 58,658.49	$ 166,199.04
Osteoarthritis	Cross-Linked Hyaluronate	Office	$ 8,588.74	11	3	$ 780.79	$ 2,862.91
		On Campus-Outpatient Hospi	$ 998.00	1	1	$ 998.00	$ 998.00
	Hyaluronan	Office	$ 41,673.09	71	35	$ 586.94	$ 1,190.66
		On Campus-Outpatient Hospi	$ 8,659.57	14	6	$ 618.54	$ 1,443.26
	Hylan G-F 20	Office	$ 47,167.75	89	38	$ 529.97	$ 1,241.26
		On Campus-Outpatient Hospi	$ 6,831.96	10	5	$ 683.20	$ 1,366.39
Osteoporosis	Denosumab	Office	$ 181,975.72	89	40	$ 2,044.67	$ 4,549.39
		On Campus-Outpatient Hospi	$ 1,011,977.81	447	112	$ 2,263.93	$ 9,035.52
Thrombolytic	Alteplase	Emergency Room – Hospital	$ 39,250.45	4	2	$ 9,812.61	$ 19,625.23
		Home	$ 939.69	5	5	$ 187.94	$ 187.94
		Office	$ 175.34	1	1	$ 175.34	$ 175.34
		On Campus-Outpatient Hospi	$ 43,271.03	55	27	$ 786.75	$ 1,602.63
Transplant	Belatacept	Office	$ 43,225.21	39	1	$ 1,108.34	$ 43,225.21
		On Campus-Outpatient Hospi	$ 8,956.06	3	1	$ 2,985.35	$ 8,956.06
		Totals	**$ 16,036,509.18**	**3,574**		**$ 4,486.99**	
		Potential movement savings	**$ 4,211,178.11**				

On Campus-Outpatient Hospital

Diagnosis / Indication	Medication	Site of Care	Total Allowed Amount	Sum of Claim Count	Utilizing Members	Average Allowed / Claim	Average Allowed / Utilizing Members
Blood Cell Deficiency	Tbo-Filgrastim	On Campus-Outpatient Hospi	$ 295.19	2	1	$ 147.60	$ 295.19
		Unknown	$ 3,936.75	3	1	$ 1,312.25	$ 3,936.75
Hemophilia	Antihemophilic Factor (Recombinant) (rFVI	Home	$ 239,521.42	10	1	$ 23,952.14	$ 239,521.42
		Office	$ 188,576.99	7	2	$ 26,939.57	$ 94,288.50
		On Campus-Outpatient Hospi	$ 7,676.64	1	1	$ 7,676.64	$ 7,676.64
	Tenecteplase	Emergency Room – Hospital	$ 43,244.35	4	4	$ 10,811.09	$ 10,811.09
		On Campus-Outpatient Hospi	$ 50,173.94	6	4	$ 8,362.32	$ 12,543.49
Inflammatory Conditions	Certolizumab Pegol	On Campus-Outpatient Hospi	$ 138,370.01	27	2	$ 5,124.82	$ 69,185.01
		Pharmacy	$ 1,365,916.99	236	18	$ 5,787.78	$ 75,884.28
Inflammatory Conditions	Golimumab	Office	$ 45,996.00	21	3	$ 2,190.29	$ 15,332.00
		On Campus-Outpatient Hospi	$ 25,767.49	16	2	$ 1,610.47	$ 12,883.75
		Pharmacy	$ 151,226.24	27	1	$ 5,600.97	$ 151,226.24
Miscellaneous Diseases	Methylnaltrexone Bromide	Emergency Room – Hospital	$ 949.21	1	1	$ 949.21	$ 949.21
		On Campus-Outpatient Hospi	$ 468.00	1	1	$ 468.00	$ 468.00
Miscellaneous Specialty C	Collagenase Clostridium Histolyticum	Office	$ 114,338.48	28	6	$ 4,083.52	$ 19,056.41
		On Campus-Outpatient Hospi	$ 7,449.30	2	1	$ 3,724.65	$ 7,449.30
Ophthalmic Conditions	Aflibercept	Office	$ 1,046,590.10	473	65	$ 2,212.66	$ 16,101.39
		On Campus-Outpatient Hospi	$ 44,684.56	26	4	$ 1,718.64	$ 11,171.14
	Ranibizumab	Office	$ 69,219.72	31	6	$ 2,232.89	$ 11,536.62
		On Campus-Outpatient Hospi	$ 7,722.93	6	1	$ 1,287.16	$ 7,722.93
		Totals	**$ 3,552,124.31**	**928**		**$ 3,827.72**	
		Potential movement savings	**$ 860,787.17**				

Federally Qualified Health Center

Diagnosis / Indication	Medication	Site of Care	Total Allowed Amount	Sum of Claim Count	Utilizing Members	Average Allowed / Claim	Average Allowed / Utilizing Members
Contraception	Levonorgestrel (IUD)	Ambulatory Surgical Center	$ 4,420.00	4	4	$ 1,105.00	$ 1,105.00
		Federally Qualified Health Ce	$ 759.00	1	1	$ 759.00	$ 759.00
		Office	$ 386,993.04	337	331	$ 1,148.35	$ 1,169.16
		On Campus-Outpatient Hospi	$ 20,334.19	15	14	$ 1,355.61	$ 1,452.44
		Pharmacy	$ 36,509.17	35	35	$ 1,043.12	$ 1,043.12
		Totals	**$ 449,015.40**	**392**		**$ 1,145.45**	
		Potential movement savings	**$ 151,487.40**				

Unknown

Diagnosis / Indication	Medication	Site of Care	Total Allowed Amount	Sum of Claim Count	Utilizing Members	Average Allowed / Claim	Average Allowed / Utilizing Members
Blood Cell Deficiency	Epoetin Alfa	On Campus-Outpatient Hospi	$ 2,378.66	1	1	$ 2,378.66	$ 2,378.66
		Unknown	$ 2,037.04	2	1	$ 1,018.52	$ 2,037.04
Blood Cell Deficiency	Filgrastim	On Campus-Outpatient Hospi	$ 1,115.78	1	1	$ 1,115.78	$ 1,115.78
		Unknown	$ 1,840.96	2	1	$ 920.48	$ 1,840.96
		Totals	**$ 7,372.44**	**6**		**$ 1,228.74**	
		Potential movement savings	**$ 1,555.44**				

Ambulatory Surgical Center

Diagnosis / Indication	Medication	Site of Care	Total Allowed Amount	Sum of Claim Count	Utilizing Members	Average Allowed / Claim	Average Allowed / Utilizing Members
Miscellaneous Specialty C	OnabotulinumtoxinA	Ambulatory Surgical Center	$ 1,315.43	2	2	$ 657.72	$ 657.72
		Office	$ 550,660.16	578	108	$ 952.70	$ 5,098.71
		On Campus-Outpatient Hospi	$ 83,406.75	42	17	$ 1,985.88	$ 4,906.28
		Totals	**$ 635,382.34**	**622**		**$ 1,021.52**	
		Potential movement savings	**$ 226,283.61**				

EXHIBIT 2

One channel/Site of Care - detailed listing by site of care and which medications were dispensed.

Site of Care	Medication	Diagnosis / Indication	Route of Admin	Total Allowed Amount	Sum of Claim Count	Utilizing Members	Average Allowed / Claim	Average Allowed / Utilizing Members
Emergency Room – Hospital	Prothrombin Complex Concentrate Huma	Hemophilia	IV	$ 22,434.09	2	2	$ 11,217.05	$ 11,217.05
End-Stage Renal Disease Treatme	Methoxy Polyethylene Glycol-Epoetin Bet	Blood Cell Deficiency	SC	$ 567,272.04	46	8	$ 12,332.00	$ 70,909.01
Home	Antihemophilic Factor (Recombinant) Sin	Hemophilia	IV	$ 12,043.72	3	2	$ 4,014.57	$ 6,021.86
Home	Ziconotide Acetate	Miscellaneous Specialty Conditi	IJ	$ 9,105.00	1	1	$ 9,105.00	$ 9,105.00
Office	Eptinezumab-jjmr	Miscellaneous Specialty Conditi	IV	$ 7,004.29	2	1	$ 3,502.15	$ 7,004.29
Office	IncobotulinumtoxinA	Miscellaneous Specialty Conditi	IJ	$ 12,121.00	12	3	$ 1,010.08	$ 4,040.33
Office	Onasemnogene Abeparvovec-xioi	Muscular Atrophy	IJ	$ 2,127,500.00	1	1	$ 2,127,500.00	$ 2,127,500.00
Office	Teprotumumab-trbw	Thyroid Eye Disease	IV	$ 295,196.44	16	2	$ 18,449.78	$ 147,598.22
Office	Verteporfin	Ophthalmic Conditions	IV	$ 3,372.60	4	1	$ 843.15	$ 3,372.60
On Campus-Outpatient Hospital	AbobotulinumtoxinA	Miscellaneous Specialty Conditi	IM	$ 4,916.41	2	1	$ 2,458.21	$ 4,916.41
On Campus-Outpatient Hospital	Eptifibatide	Hemophilia	IV	$ 4,935.00	1	1	$ 4,935.00	$ 4,935.00
On Campus-Outpatient Hospital	Lanreotide Acetate	Endocrine Disorder	SC	$ 481,626.70	24	3	$ 20,067.78	$ 160,542.23
On Campus-Outpatient Hospital	Remdesivir	COVID-19	IV	$ 45,024.20	25	10	$ 1,800.97	$ 4,502.42
On Campus-Outpatient Hospital	RimabotulinumtoxinB	Miscellaneous Specialty Conditi	IM	$ 6,073.33	6	1	$ 1,012.22	$ 6,073.33
On Campus-Outpatient Hospital	Romosozumab-aqqg	Osteoporosis	SC	$ 5,860.99	3	1	$ 1,953.66	$ 5,860.99
Pharmacy	Abaloparatide	Osteoporosis	SC	$ 49,409.20	21	2	$ 2,352.82	$ 24,704.60
Pharmacy	Adalimumab	Inflammatory Conditions	SC	$ 12,791,353.60	1663	116	$ 7,691.73	$ 110,270.29
Pharmacy	Adalimumab-adaz	Inflammatory Conditions	SC	$ 1,437.21	1	1	$ 1,437.21	$ 1,437.21
Pharmacy	Adalimumab-bwwd	Inflammatory Conditions	SC	$ 2,028.22	1	1	$ 2,028.22	$ 2,028.22
Pharmacy	Ambrisentan	Pulmonary Hypertension	OR	$ 12,817.41	3	2	$ 4,272.47	$ 6,408.71
Pharmacy	Apremilast	Inflammatory Conditions	OR	$ 1,717,795.79	408	33	$ 4,210.28	$ 52,054.42
Pharmacy	Baricitinib	Inflammatory Conditions	OR	$ 133,304.12	41	5	$ 3,251.32	$ 26,660.82
Pharmacy	Belumosudil Mesylate	Miscellaneous Specialty Conditi	OR	$ 119,820.05	7	1	$ 17,117.15	$ 119,820.05
Pharmacy	Bictegravir-Emtricitabine-Tenofovir Alafe	HIV	OR	$ 521,132.06	148	9	$ 3,521.16	$ 57,903.56
Pharmacy	Cannabidiol	Miscellaneous Specialty Conditi	OR	$ 23,543.29	7	1	$ 3,363.33	$ 23,543.29
Pharmacy	Chorionic Gonadotropin	Infertility	IM	$ 28,493.59	29	2	$ 982.54	$ 14,246.80
Pharmacy	Corticotropin	Endocrine Disorder	IJ	$ 552,918.47	13	1	$ 42,532.19	$ 552,918.47
Pharmacy	Darunavir	HIV	OR	$ 1,478.82	1	1	$ 1,478.82	$ 1,478.82
Pharmacy	Darunavir-Cobicistat	HIV	OR	$ 8,440.81	4	1	$ 2,110.20	$ 8,440.81
Pharmacy	Decitabine-Cedazuridine	Myelodysplastic syndromes (MI	OR	$ 15,228.64	2	1	$ 7,614.32	$ 15,228.64
Pharmacy	Deflazacort	Muscular Dystrophy	OR	$ 217,522.07	37	1	$ 5,878.97	$ 217,522.07
Pharmacy	Diroximel Fumarate	Multiple Sclerosis (MS)	OR	$ 101,300.86	13	1	$ 7,792.37	$ 101,300.86
Pharmacy	Dolutegravir Sodium	HIV	OR	$ 13,632.81	7	3	$ 1,947.54	$ 4,544.27
Pharmacy	Dornase Alfa	Cystic Fibrosis	IN	$ 98,858.98	21	3	$ 4,707.57	$ 32,952.99
Pharmacy	Dupilumab	Asthma & Allergy	SC	$ 1,908,243.74	532	50	$ 3,586.92	$ 38,164.87
Pharmacy	Eculizumab	Miscellaneous Specialty Conditi	IV	$ 821,916.90	30	1	$ 27,397.23	$ 821,916.90
Pharmacy	Efavirenz-Lamivudine-Tenofovir Disoprox	HIV	OR	$ 15,610.78	14	1	$ 1,115.06	$ 15,610.78
Pharmacy	Elexacaftor-Tezacaftor-Ivacaftor	Cystic Fibrosis	OR	$ 1,820,138.02	73	6	$ 24,933.40	$ 303,356.34
Pharmacy	Elvitegravir-Cobicistat-Emtricitabine-Ten	HIV	OR	$ 73,800.57	21	3	$ 3,514.31	$ 24,600.19
Pharmacy	Emtricitabine-Tenofovir Alafenamide Fun	HIV	OR	$ 7,831.12	4	1	$ 1,957.78	$ 7,831.12
Pharmacy	Entecavir	Hepatitis B	OR	$ 407.04	26	2	$ 15.66	$ 203.52
Pharmacy	Etanercept	Inflammatory Conditions	SC	$ 5,013,869.17	785	59	$ 6,387.09	$ 84,980.83
Pharmacy	Everolimus (Immunosuppressant)	Transplant	IV	$ 48,110.31	28	1	$ 1,718.23	$ 48,110.31
Pharmacy	Evolocumab	Hypercholesterolemia	SC	$ 106,758.62	213	19	$ 501.21	$ 5,618.87
Pharmacy	Filgrastim-aafi	Blood Cell Deficiency	IJ	$ 5,696.62	6	2	$ 949.44	$ 2,848.31
Pharmacy	Filgrastim-sndz	Blood Cell Deficiency	IJ	$ 6,838.29	4	3	$ 1,709.57	$ 2,279.43
Pharmacy	Fingolimod HCl	Multiple Sclerosis (MS)	OR	$ 914,223.12	173	9	$ 5,284.53	$ 101,580.35
Pharmacy	Glatiramer Acetate	Multiple Sclerosis (MS)	SC	$ 754,307.82	269	17	$ 2,804.12	$ 44,371.05
Pharmacy	Glecaprevir-Pibrentasvir	Hepatitis C	OR	$ 129,229.30	10	5	$ 12,922.93	$ 25,845.86
Pharmacy	Glycopyrrolate	Cerabral Palsy	OR	$ 1,594.45	125	21	$ 12.76	$ 75.93
Pharmacy	Guselkumab	Inflammatory Conditions	SC	$ 1,386,705.39	111	14	$ 12,492.84	$ 99,050.39
Pharmacy	Icatibant Acetate	Hereditary Angioedema	SC	$ 32,898.65	1	1	$ 32,898.65	$ 32,898.65
Pharmacy	Interferon Beta-1a	Multiple Sclerosis (MS)	IM, SC	$ 1,252,483.28	148	8	$ 8,462.72	$ 156,560.41
Pharmacy	Interferon Beta-1b	Multiple Sclerosis (MS)	SC	$ 137,011.03	16	1	$ 8,563.19	$ 137,011.03
Pharmacy	Ixekizumab	Inflammatory Conditions	SC	$ 2,036,384.36	285	25	$ 7,145.21	$ 81,455.37
Pharmacy	Macitentan	Pulmonary Hypertension	OR	$ 11,763.81	1	1	$ 11,763.81	$ 11,763.81
Pharmacy	Mechlorethamine HCl (Topical)	Infection	EX	$ 55,926.88	10	1	$ 5,592.69	$ 55,926.88
Pharmacy	Mifepristone (Hyperglycemia)	Endocrine Disorder	OR	$ 26,276.58	1	1	$ 26,276.58	$ 26,276.58
Pharmacy	Pegfilgrastim-jmdb	Blood Cell Deficiency	SC	$ 17,158.87	5	3	$ 3,431.77	$ 5,719.62
Pharmacy	Peginterferon Beta-1a	Multiple Sclerosis (MS)	SC	$ 295,997.34	39	2	$ 7,589.68	$ 147,998.67
Pharmacy	Pirfenidone	Pulmonary Hypertension	OR	$ 440,505.01	67	3	$ 6,574.70	$ 146,835.00
Pharmacy	Posaconazole	Infection	OR	$ 11,637.42	10	3	$ 1,163.74	$ 3,879.14
Pharmacy	Raltegravir Potassium	HIV	OR	$ 3,678.34	2	2	$ 1,839.17	$ 1,839.17
Pharmacy	Rilpivirine HCl	HIV	OR	$ 1,239.66	1	1	$ 1,239.66	$ 1,239.66

Pharmacy	Riociguat	Pulmonary Hypertension	OR	$ 598,186.35	49	2	$ 12,207.88	$ 299,093.18
Pharmacy	Risankizumab-rzaa	Inflammatory Conditions	SC	$ 3,610,531.26	195	38	$ 18,515.54	$ 95,013.98
Pharmacy	Rufinamide	Miscellaneous Specialty Conditi	OR	$ 11,137.87	13	1	$ 856.76	$ 11,137.87
Pharmacy	Sapropterin Dihydrochloride	Enzyme Deficiency	OR	$ 11,594.97	5	1	$ 2,318.99	$ 11,594.97
Pharmacy	Sarilumab	Inflammatory Conditions	SC	$ 138,365.13	35	3	$ 3,953.29	$ 46,121.71
Pharmacy	Secukinumab	Inflammatory Conditions	SC	$ 190,740.25	26	4	$ 7,336.16	$ 47,685.06
Pharmacy	Sodium Oxybate	Miscellaneous Specialty Conditi	OR	$ 132,520.50	7	1	$ 18,931.50	$ 132,520.50
Pharmacy	Sodium Phenylbutyrate-Taurursodiol	Amyotrophic lateral sclerosis (A	OR	$ 33,091.16	3	1	$ 11,030.39	$ 33,091.16
Pharmacy	Somatropin	Growth Deficiency	IJ, SC	$ 370,194.27	123	9	$ 3,009.71	$ 41,132.70
Pharmacy	Tafamidis	Miscellaneous Diseases	OR	$ 118,456.03	6	1	$ 19,742.67	$ 118,456.03
Pharmacy	Tedizolid Phosphate	Infection	OR	$ 7,291.47	3	1	$ 2,430.49	$ 7,291.47
Pharmacy	Telotristat Etiprate	Miscellaneous Specialty Conditi	OR	$ 24,057.96	3	1	$ 8,019.32	$ 24,057.96
Pharmacy	Tenofovir Alafenamide Fumarate	Hepatitis B	OR	$ 20,291.23	16	1	$ 1,268.20	$ 20,291.23
Pharmacy	Teriflunomide	Multiple Sclerosis (MS)	OR	$ 1,123,365.82	195	14	$ 5,760.85	$ 80,240.42
Pharmacy	Teriparatide (Recombinant)	Osteoporosis	SC	$ 353,571.11	89	10	$ 3,972.71	$ 35,357.11
Pharmacy	Tobramycin	Cystic Fibrosis	IN	$ 22,220.92	5	1	$ 4,444.18	$ 22,220.92
Pharmacy	Tofacitinib Citrate	Inflammatory Conditions	OR	$ 980,054.42	188	16	$ 5,213.06	$ 61,253.40
Pharmacy	Tolvaptan	Miscellaneous Specialty Conditi	OR	$ 987,084.91	56	3	$ 17,626.52	$ 329,028.30
Pharmacy	Upadacitinib	Inflammatory Conditions	OR	$ 1,298,214.49	229	19	$ 5,669.06	$ 68,327.08
Pharmacy	Ustekinumab	Inflammatory Conditions	SC	$ 5,092,739.77	297	32	$ 17,147.27	$ 159,148.12
Pharmacy	Valbenazine Tosylate	Miscellaneous Diseases	OR	$ 7,374.72	1	1	$ 7,374.72	$ 7,374.72
Pharmacy	Vigabatrin	Miscellaneous Specialty Conditi	OR	$ 13,140.24	2	1	$ 6,570.12	$ 13,140.24
Pharmacy	Vosoritide	Miscellaneous Specialty Conditi	IJ	$ 475,452.08	17	1	$ 27,967.77	$ 475,452.08
Unknown	Plerixafor	Blood Cell Deficiency	SC	$ 14,782.76	2	1	$ 7,391.38	$ 14,782.76
		Totals		**$ 52,987,703.99**	**7,150**			

EXHIBIT 3

Detailed list of medications excluded from the analysis.

Site of Care	Medication	Diagnosis / Indication	Total Allowed Amount	Sum of Claim Count	Utilizing Members	Average Allowed / Claim	Average Allowed / Utilizing Members
Ambulance - Land	Naloxone HCl	Miscellaneous Diseases	$ 172.17	3	2	$ 57.39	$ 86.09
Ambulatory Surgical Center	Mitomycin	Oncology	$ 50.66	1	1	$ 50.66	$ 50.66
Emergency Room – Hospital	Enoxaparin Sodium	Anticoagulant	$ 2,790.59	61	37	$ 45.75	$ 75.42
Emergency Room – Hospital	Furosemide	Edema	$ 394.82	20	17	$ 19.74	$ 23.22
Emergency Room – Hospital	Ketorolac Tromethamine	Miscellaneous Specialty Condit	$ 11,688.55	604	512	$ 19.35	$ 22.83
Emergency Room – Hospital	Methotrexate	Miscellaneous Diseases	$ 52.48	2	2	$ 26.24	$ 26.24
Emergency Room – Hospital	Mycophenolate Mofetil	Transplant	$ 39.66	2	1	$ 19.83	$ 39.66
Emergency Room – Hospital	Naloxone HCl	Miscellaneous Diseases	$ 431.91	9	9	$ 47.99	$ 47.99
Emergency Room – Hospital	Rho D Immune Globulin (Human)	Hemophilia	$ 961.48	3	3	$ 320.49	$ 320.49
Emergency Room – Hospital	Sumatriptan Succinate	Miscellaneous Specialty Condit	$ 240.09	3	3	$ 80.03	$ 80.03
Emergency Room – Hospital	Triamcinolone Acetonide	Osteoarthritis	$ 85.17	3	3	$ 28.39	$ 28.39
Federally Qualified Health (	Ketorolac Tromethamine	Miscellaneous Specialty Condit	$ 1.99	2	2	$ 1.00	$ 1.00
Federally Qualified Health (	Triamcinolone Acetonide	Osteoarthritis	$ 1.77	1	1	$ 1.77	$ 1.77
Home	Daptomycin	Infection	$ 4,417.13	15	2	$ 294.48	$ 2,208.57
Home	Fluorouracil	Oncology	$ 476.92	18	2	$ 26.50	$ 238.46
Home	Mycophenolate Mofetil	Transplant	$ 1,521.00	60	5	$ 25.35	$ 304.20
Home	Mycophenolate Sodium	Transplant	$ 13,349.51	75	7	$ 177.99	$ 1,907.07
Home	Sirolimus (Bulk)	Transplant	$ 2,053.33	19	1	$ 108.07	$ 2,053.33
Home	Zoledronic Acid	Osteoporosis	$ 305.90	2	2	$ 152.95	$ 152.95
Inpatient Hospital	Chlorambucil	Oncology	$ 10.06	1	1	$ 10.06	$ 10.06
Inpatient Hospital	Enoxaparin Sodium	Anticoagulant	$ 625.76	16	9	$ 39.11	$ 69.53
Inpatient Hospital	Furosemide	Edema	$ 443.27	20	6	$ 22.16	$ 73.88
Inpatient Hospital	Ketorolac Tromethamine	Miscellaneous Specialty Condit	$ 86.61	17	7	$ 5.09	$ 12.37
Inpatient Hospital	Naloxone HCl	Miscellaneous Diseases	$ 41.14	2	1	$ 20.57	$ 41.14
Off Campus-Outpatient Hos	Triamcinolone Acetonide	Osteoarthritis	$ 1.25	1	1	$ 1.25	$ 1.25
Office	Bevacizumab	Oncology	$ 28,672.65	300	55	$ 95.58	$ 521.32
Office	Carboplatin	Oncology	$ 683.75	18	4	$ 37.99	$ 170.94
Office	Daptomycin	Infection	$ 1,216.49	11	1	$ 110.59	$ 1,216.49
Office	Daratumumab	Oncology	$ 160,502.67	20	1	$ 8,025.13	$ 160,502.67
Office	Decitabine	Oncology	$ 3,315.77	76	1	$ 43.63	$ 3,315.77
Office	Degarelix Acetate	Oncology	$ 974.64	1	1	$ 974.64	$ 974.64
Office	Docetaxel	Oncology	$ 1,924.76	8	1	$ 240.60	$ 1,924.76
Office	Doxorubicin HCl	Oncology	$ 765.70	8	3	$ 95.71	$ 255.23
Office	Enoxaparin Sodium	Anticoagulant	$ 4.88	1	1	$ 4.88	$ 4.88
Office	Fluorouracil	Oncology	$ 706.34	22	5	$ 32.11	$ 141.27
Office	Furosemide	Edema	$ 5.94	3	3	$ 1.98	$ 1.98
Office	Gemcitabine HCl	Oncology	$ 1,443.45	28	4	$ 51.55	$ 360.86
Office	Goserelin Acetate	Oncology	$ 2,418.42	2	1	$ 1,209.21	$ 2,418.42
Office	Granisetron HCl	Chemotherapy side effect redu	$ 10.80	1	1	$ 10.80	$ 10.80
Office	Irinotecan HCl	Oncology	$ 124.21	5	1	$ 24.84	$ 124.21
Office	Ketorolac Tromethamine	Miscellaneous Specialty Condit	$ 1,049.21	605	483	$ 1.73	$ 2.17
Office	Leucovorin Calcium	Miscellaneous Specialty Condit	$ 1,278.34	14	2	$ 91.31	$ 639.17
Office	Methotrexate Sodium	Inflammatory Conditions	$ 27.65	4	3	$ 6.91	$ 9.22
Office	Nivolumab	Oncology	$ 104,497.91	4	1	$ 26,124.48	$ 104,497.91
Office	Oxaliplatin	Oncology	$ 1,177.70	11	2	$ 107.06	$ 588.85
Office	Paclitaxel	Oncology	$ 1,783.80	39	5	$ 45.74	$ 356.76
Office	Paclitaxel Protein-Bound Particles	Oncology	$ 27,654.17	18	2	$ 1,536.34	$ 13,827.09
Office	Pemetrexed Disodium	Oncology	$ 32,121.56	3	1	$ 10,707.19	$ 32,121.56
Office	Rho D Immune Globulin (Human)	Hemophilia	$ 9,610.60	83	76	$ 115.79	$ 126.46
Office	Rituximab	Oncology	$ 475,172.40	60	10	$ 7,919.54	$ 47,517.24
Office	Sodium Hyaluronate (Viscosupplement)	Osteoarthritis	$ 32,554.22	223	42	$ 145.98	$ 775.10
Office	Sumatriptan Succinate	Miscellaneous Specialty Condit	$ 366.74	9	6	$ 40.75	$ 61.12
Office	Thyrotropin Alfa	Oncology	$ 3,849.88	2	1	$ 1,924.94	$ 3,849.88
Office	Triamcinolone Acetonide	Osteoarthritis	$ 12,644.40	1,583	980	$ 7.99	$ 12.90
Office	Vincristine Sulfate	Oncology	$ 75.45	5	1	$ 15.09	$ 75.45
Office	Zoledronic Acid	Osteoporosis	$ 2,715.58	33	25	$ 82.29	$ 108.62

On Campus-Outpatient Hos	Ado-Trastuzumab Emtansine	Oncology	$ 88,094.32	7	1	$12,584.90	$ 88,094.32
On Campus-Outpatient Hos	Amiodarone HCl in Dextrose	Antiarrhythmic Medication	$ 78.45	1	1	$ 78.45	$ 78.45
On Campus-Outpatient Hos	Atezolizumab	Oncology	$ 344,024.31	15	2	$22,934.95	$ 172,012.16
On Campus-Outpatient Hos	Avelumab	Oncology	$ 131,781.99	14	1	$ 9,413.00	$ 131,781.99
On Campus-Outpatient Hos	Azacitidine	Oncology	$ 10,473.71	82	3	$ 127.73	$ 3,491.24
On Campus-Outpatient Hos	Azathioprine	Transplant	$ 14.48	2	1	$ 7.24	$ 14.48
On Campus-Outpatient Hos	Belinostat	Oncology	$ 116,938.84	12	1	$ 9,744.90	$ 116,938.84
On Campus-Outpatient Hos	Bendamustine HCl	Oncology	$ 43,579.69	15	1	$ 2,905.31	$ 43,579.69
On Campus-Outpatient Hos	Bevacizumab	Oncology	$ 447,154.81	39	2	$11,465.51	$ 223,577.41
On Campus-Outpatient Hos	Bleomycin Sulfate	Oncology	$ 1,592.99	9	1	$ 177.00	$ 1,592.99
On Campus-Outpatient Hos	Bortezomib	Oncology	$ 236,105.91	75	6	$ 3,148.08	$ 39,350.99
On Campus-Outpatient Hos	Brentuximab Vedotin	Oncology	$ 552,087.54	12	1	$46,007.30	$ 552,087.54
On Campus-Outpatient Hos	Cabazitaxel	Oncology	$ 1,217,387.99	15	1	$81,159.20	$ 1,217,387.99
On Campus-Outpatient Hos	Carboplatin	Oncology	$ 11,877.42	62	16	$ 191.57	$ 742.34
On Campus-Outpatient Hos	Carfilzomib	Oncology	$ 43,973.01	10	1	$ 4,397.30	$ 43,973.01
On Campus-Outpatient Hos	Cisplatin	Oncology	$ 17,845.81	50	7	$ 356.92	$ 2,549.40
On Campus-Outpatient Hos	Daptomycin	Infection	$ 22,905.99	80	6	$ 286.32	$ 3,817.67
On Campus-Outpatient Hos	Daratumumab	Oncology	$ 27,459.67	1	1	$27,459.67	$ 27,459.67
On Campus-Outpatient Hos	Daratumumab-Hyaluronidase-fihj	Oncology	$ 1,101,528.42	53	7	$20,783.56	$ 157,361.20
On Campus-Outpatient Hos	Decitabine	Oncology	$ 65,144.42	243	3	$ 268.08	$ 21,714.81
On Campus-Outpatient Hos	Degarelix Acetate	Oncology	$ 974.64	2	1	$ 487.32	$ 974.64
On Campus-Outpatient Hos	Docetaxel	Oncology	$ 30,303.01	65	12	$ 466.20	$ 2,525.25
On Campus-Outpatient Hos	Doxorubicin HCl	Oncology	$ 9,453.43	42	10	$ 225.08	$ 945.34
On Campus-Outpatient Hos	Enfortumab Vedotin-ejfv	Oncology	$ 97,961.84	7	1	$13,994.55	$ 97,961.84
On Campus-Outpatient Hos	Enoxaparin Sodium	Anticoagulant	$ 9,635.17	144	100	$ 66.91	$ 96.35
On Campus-Outpatient Hos	Etoposide	Oncology	$ 6,893.69	24	2	$ 287.24	$ 3,446.85
On Campus-Outpatient Hos	Fam-Trastuzumab Deruxtecan-nxki	Oncology	$ 209,215.93	10	2	$20,921.59	$ 104,607.97
On Campus-Outpatient Hos	Fluorouracil	Oncology	$ 54,011.79	343	14	$ 157.47	$ 3,857.99
On Campus-Outpatient Hos	Fondaparinux Sodium	Anticoagulant	$ 57.79	4	4	$ 14.45	$ 14.45
On Campus-Outpatient Hos	Fosaprepitant Dimeglumine	Chemotherapy side effect redu	$ 22,919.13	91	14	$ 251.86	$ 1,637.08
On Campus-Outpatient Hos	Fulvestrant	Oncology	$ 53,262.44	27	4	$ 1,972.68	$ 13,315.61
On Campus-Outpatient Hos	Furosemide	Edema	$ 1,912.44	75	52	$ 25.50	$ 36.78
On Campus-Outpatient Hos	Gemcitabine HCl	Oncology	$ 12,522.15	91	10	$ 137.61	$ 1,252.22
On Campus-Outpatient Hos	Gemtuzumab Ozogamicin	Oncology	$ 78,954.00	3	1	$26,318.00	$ 78,954.00
On Campus-Outpatient Hos	Goserelin Acetate	Oncology	$ 25,810.30	10	1	$ 2,581.03	$ 25,810.30
On Campus-Outpatient Hos	Granisetron HCl	Chemotherapy side effect redu	$ 15.07	2	1	$ 7.54	$ 15.07
On Campus-Outpatient Hos	Ipilimumab	Oncology	$ 293,300.30	18	5	$16,294.46	$ 58,660.06
On Campus-Outpatient Hos	Irinotecan HCl	Oncology	$ 12,205.30	107	7	$ 114.07	$ 1,743.61
On Campus-Outpatient Hos	Irinotecan HCl Liposome	Oncology	$ 663,058.57	56	1	$11,840.33	$ 663,058.57
On Campus-Outpatient Hos	Ketorolac Tromethamine	Miscellaneous Specialty Condit	$ 40,407.98	1,683	1233	$ 24.01	$ 32.77
On Campus-Outpatient Hos	Leucovorin Calcium	Miscellaneous Specialty Condit	$ 26,279.42	184	13	$ 142.82	$ 2,021.49
On Campus-Outpatient Hos	Levoleucovorin	Oncology	$ 6,546.61	94	2	$ 69.64	$ 3,273.31
On Campus-Outpatient Hos	Lurbinectedin	Oncology	$ 123,567.54	12	1	$10,297.30	$ 123,567.54
On Campus-Outpatient Hos	Methotrexate	Miscellaneous Diseases	$ 113.50	4	3	$ 28.38	$ 37.83
On Campus-Outpatient Hos	Mitomycin	Oncology	$ 6,938.96	6	5	$ 1,156.49	$ 1,387.79
On Campus-Outpatient Hos	Mycophenolate Mofetil	Transplant	$ 30.47	2	2	$ 15.24	$ 15.24
On Campus-Outpatient Hos	Naloxone HCl	Miscellaneous Diseases	$ 654.13	11	11	$ 59.47	$ 59.47
On Campus-Outpatient Hos	Nivolumab	Oncology	$ 2,147,959.99	120	12	$17,899.67	$ 178,996.67
On Campus-Outpatient Hos	Nivolumab-Relatlimab-rmbw	Oncology	$ 339,911.64	9	1	$37,767.96	$ 339,911.64
On Campus-Outpatient Hos	Obinutuzumab	Oncology	$ 103,722.76	3	1	$34,574.25	$ 103,722.76
On Campus-Outpatient Hos	Oxaliplatin	Oncology	$ 45,573.79	137	13	$ 332.66	$ 3,505.68
On Campus-Outpatient Hos	Paclitaxel	Oncology	$ 15,064.04	61	9	$ 246.95	$ 1,673.78
On Campus-Outpatient Hos	Paclitaxel Protein-Bound Particles	Oncology	$ 261,997.11	58	6	$ 4,517.19	$ 43,666.19
On Campus-Outpatient Hos	Pemetrexed Disodium	Oncology	$ 179,450.98	28	5	$ 6,408.96	$ 35,890.20
On Campus-Outpatient Hos	Pentamidine Isethionate	Pneumonia	$ 350.59	1	1	$ 350.59	$ 350.59
On Campus-Outpatient Hos	Pertuzumab	Oncology	$ 414,156.61	34	5	$12,181.08	$ 82,831.32
On Campus-Outpatient Hos	Pertuzumab-Trastuzumab-Hyaluronidase-	Oncology	$ 668,533.21	23	1	$29,066.66	$ 668,533.21
On Campus-Outpatient Hos	Propranolol HCl	Miscellaneous Specialty Condit	$ 98.25	1	1	$ 98.25	$ 98.25
On Campus-Outpatient Hos	Rasburicase	Oncology	$ 14,445.32	1	1	$14,445.32	$ 14,445.32
On Campus-Outpatient Hos	Rho D Immune Globulin (Human)	Hemophilia	$ 995.76	9	9	$ 110.64	$ 110.64
On Campus-Outpatient Hos	Rituximab	Oncology	$ 335,668.37	20	6	$16,783.42	$ 55,944.73
On Campus-Outpatient Hos	Sacituzumab Govitecan-hziy	Oncology	$ 886,944.18	45	2	$19,709.87	$ 443,472.09
On Campus-Outpatient Hos	Sumatriptan Succinate	Miscellaneous Specialty Condit	$ 639.01	3	3	$ 213.00	$ 213.00
On Campus-Outpatient Hos	Thyrotropin Alfa	Oncology	$ 9,624.00	2	1	$ 4,812.00	$ 9,624.00
On Campus-Outpatient Hos	Topotecan HCl	Oncology	$ 1,055.91	10	1	$ 105.59	$ 1,055.91
On Campus-Outpatient Hos	Trabectedin	Oncology	$ 124,230.59	7	1	$17,747.23	$ 124,230.59
On Campus-Outpatient Hos	Trastuzumab	Oncology	$ 11,103.75	2	1	$ 5,551.88	$ 11,103.75
On Campus-Outpatient Hos	Triamcinolone Acetonide	Osteoarthritis	$ 11,219.66	182	126	$ 61.65	$ 89.04
On Campus-Outpatient Hos	Vincristine Sulfate	Oncology	$ 1,841.32	14	4	$ 131.52	$ 460.33
On Campus-Outpatient Hos	Zoledronic Acid	Osteoporosis	$ 20,007.87	54	34	$ 370.52	$ 588.47

Pharmacy	Abemaciclib	Oncology	$ 150,250.18	11	1	$13,659.11	$ 150,250.18
Pharmacy	Abiraterone Acetate	Oncology	$ 24,425.35	81	9	$ 301.55	$ 2,713.93
Pharmacy	Acalabrutinib	Oncology	$ 155,989.21	17	2	$ 9,175.84	$ 77,994.61
Pharmacy	Acalabrutinib Maleate	Oncology	$ 321,265.69	31	4	$10,363.41	$ 80,316.42
Pharmacy	Alirocumab	Hypercholesterolemia	$ 27,087.05	66	5	$ 410.41	$ 5,417.41
Pharmacy	Alpelisib	Oncology	$ 36,396.64	2	1	$18,198.32	$ 36,396.64
Pharmacy	Amantadine HCl	Antiviral	$ 4,081.49	183	21	$ 22.30	$ 194.36
Pharmacy	Apalutamide	Oncology	$ 302,656.28	22	1	$13,757.10	$ 302,656.28
Pharmacy	Azathioprine	Transplant	$ 8,170.88	476	38	$ 17.17	$ 215.02
Pharmacy	Bexarotene	Oncology	$ 23,331.53	27	2	$ 864.13	$ 11,665.77
Pharmacy	Bicalutamide	Oncology	$ 1,002.37	59	13	$ 16.99	$ 77.11
Pharmacy	Bimatoprost	Ophthalmic Conditions	$ 150,649.52	667	57	$ 225.86	$ 2,642.97
Pharmacy	Brigatinib	Oncology	$ 292,297.32	24	1	$12,179.06	$ 292,297.32
Pharmacy	Budesonide	Inflammatory Conditions	$ 86,128.43	416	69	$ 207.04	$ 1,248.24
Pharmacy	Buprenorphine	Miscellaneous Diseases	$ 23,081.23	90	14	$ 256.46	$ 1,648.66
Pharmacy	Buprenorphine HCl	Miscellaneous Diseases	$ 5,686.74	161	11	$ 35.32	$ 516.98
Pharmacy	Cabozantinib S-Malate	Oncology	$ 349,997.49	20	3	$17,499.87	$ 116,665.83
Pharmacy	Capecitabine	Oncology	$ 4,075.70	66	7	$ 61.75	$ 582.24
Pharmacy	Carbidopa-Levodopa	Miscellaneous Specialty Condit	$ 40,399.08	990	61	$ 40.81	$ 662.28
Pharmacy	Cinacalcet HCl	Renal Disorder	$ 8,566.09	104	8	$ 82.37	$ 1,070.76
Pharmacy	Cyclosporine	Transplant	$ 7,369.20	24	3	$ 307.05	$ 2,456.40
Pharmacy	Cyclosporine Modified (For Microemulsio	Transplant	$ 9,083.76	38	5	$ 239.05	$ 1,816.75
Pharmacy	Dabrafenib Mesylate	Oncology	$ 182,148.74	16	2	$11,384.30	$ 91,074.37
Pharmacy	Dalfampridine	Multiple Sclerosis (MS)	$ 5,287.87	102	9	$ 51.84	$ 587.54
Pharmacy	Dasatinib	Oncology	$ 179,383.01	15	2	$11,958.87	$ 89,691.51
Pharmacy	Deferasirox	Iron Toxicity	$ 3,526.97	21	1	$ 167.95	$ 3,526.97
Pharmacy	Desmopressin Acetate Spray	Hemophilia	$ 488.02	10	2	$ 48.80	$ 244.01
Pharmacy	Desmopressin Acetate Spray Refrigerated	Hemophilia	$ 5,131.50	41	3	$ 125.16	$ 1,710.50
Pharmacy	Dimethyl Fumarate	Multiple Sclerosis (MS)	$ 8,561.81	56	3	$ 152.89	$ 2,853.94
Pharmacy	Efavirenz	HIV	$ 2,216.76	14	1	$ 158.34	$ 2,216.76
Pharmacy	Emtricitabine	HIV	$ 378.93	1	1	$ 378.93	$ 378.93
Pharmacy	Emtricitabine-Tenofovir Disoproxil Fumar	HIV	$ 7,819.54	338	35	$ 23.13	$ 223.42
Pharmacy	Enasidenib Mesylate	Oncology	$ 60,674.96	2	1	$30,337.48	$ 60,674.96
Pharmacy	Enoxaparin Sodium	Anticoagulant	$ 48,186.29	288	146	$ 167.31	$ 330.04
Pharmacy	Enzalutamide	Oncology	$ 344,116.08	42	4	$ 8,193.24	$ 86,029.02
Pharmacy	Everolimus	Oncology	$ 19,724.05	10	2	$ 1,972.41	$ 9,862.03
Pharmacy	Fondaparinux Sodium	Anticoagulant	$ 619.81	2	1	$ 309.91	$ 619.81
Pharmacy	Furosemide	Edema	$ 26,562.00	6,473	629	$ 4.10	$ 42.23
Pharmacy	Gilteritinib Fumarate	Oncology	$ 53,397.96	2	1	$26,698.98	$ 53,397.96
Pharmacy	Hydrocortisone	Miscellaneous Specialty Condit	$ 8,495.74	334	32	$ 25.44	$ 265.49
Pharmacy	Ibandronate Sodium	Osteoporosis	$ 3,709.74	405	26	$ 9.16	$ 142.68
Pharmacy	Ibrutinib	Oncology	$ 1,280,148.91	85	7	$15,060.58	$ 182,878.42
Pharmacy	Imatinib Mesylate	Oncology	$ 3,648.30	32	3	$ 114.01	$ 1,216.10
Pharmacy	Ixazomib Citrate	Oncology	$ 220,602.23	19	1	$11,610.64	$ 220,602.23
Pharmacy	Ketorolac Tromethamine	Miscellaneous Specialty Condit	$ 3,831.24	302	156	$ 12.69	$ 24.56
Pharmacy	Lamivudine	HIV	$ 715.17	14	1	$ 51.08	$ 715.17
Pharmacy	Lenalidomide	Oncology	$ 1,328,743.34	89	9	$14,929.70	$ 147,638.15
Pharmacy	Leucovorin Calcium	Miscellaneous Specialty Condit	$ 1,644.28	112	8	$ 14.68	$ 205.54
Pharmacy	Linezolid	Infection	$ 596.05	15	9	$ 39.74	$ 66.23
Pharmacy	Mercaptopurine	Inflammatory Conditions	$ 699.18	15	1	$ 46.61	$ 699.18
Pharmacy	Methotrexate Sodium	Inflammatory Conditions	$ 27,716.67	2,629	193	$ 10.54	$ 143.61
Pharmacy	Mometasone Furoate (Nasal)	Asthma & Allergy	$ 581.96	13	2	$ 44.77	$ 290.98
Pharmacy	Mycophenolate Mofetil	Transplant	$ 17,848.24	473	42	$ 37.73	$ 424.96
Pharmacy	Mycophenolate Sodium	Transplant	$ 66,641.34	225	14	$ 296.18	$ 4,760.10
Pharmacy	Naloxone HCl	Miscellaneous Diseases	$ 15,970.24	176	162	$ 90.74	$ 98.58
Pharmacy	Nilotinib HCl	Oncology	$ 92,766.61	8	1	$11,595.83	$ 92,766.61
Pharmacy	Niraparib Tosylate	Oncology	$ 38,362.68	4	1	$ 9,590.67	$ 38,362.68
Pharmacy	Olaparib	Oncology	$ 46,213.53	3	1	$15,404.51	$ 46,213.53
Pharmacy	Osimertinib Mesylate	Oncology	$ 32,624.28	4	1	$ 8,156.07	$ 32,624.28
Pharmacy	Palbociclib	Oncology	$ 265,391.96	21	2	$12,637.71	$ 132,695.98
Pharmacy	Pazopanib HCl	Oncology	$ 225,854.74	22	1	$10,266.12	$ 225,854.74
Pharmacy	Pomalidomide	Oncology	$ 187,663.86	11	2	$17,060.35	$ 93,831.93
Pharmacy	Progesterone	Contraception	$ 43,038.68	2,807	353	$ 15.33	$ 121.92
Pharmacy	Propranolol HCl	Miscellaneous Specialty Condit	$ 73,844.62	6,361	945	$ 11.61	$ 78.14
Pharmacy	Relugolix	Oncology	$ 108,245.76	22	1	$ 4,920.26	$ 108,245.76
Pharmacy	Riluzole	Amyotrophic lateral sclerosis (A	$ 2,013.66	41	4	$ 49.11	$ 503.42
Pharmacy	Risperidone	Bipolar Disorder	$ 6,810.31	643	57	$ 10.59	$ 119.48
Pharmacy	Ruxolitinib Phosphate	Oncology	$ 255,313.28	25	5	$10,212.53	$ 51,062.66
Pharmacy	Sildenafil Citrate	Erectile Dysfunction	$ 379.44	54	7	$ 7.03	$ 54.21
Pharmacy	Sildenafil Citrate (Pulmonary Hypertensio	Pulmonary Hypertension	$ 12,066.17	92	10	$ 131.15	$ 1,206.62
Pharmacy	Sirolimus	Transplant	$ 21,082.52	81	5	$ 260.28	$ 4,216.50
Pharmacy	Sumatriptan Succinate	Miscellaneous Specialty Condit	$ 34,025.41	2,463	545	$ 13.81	$ 62.43
Pharmacy	Sunitinib Malate	Oncology	$ 25,643.90	12	1	$ 2,136.99	$ 25,643.90

Pharmacy	Tadalafil	Erectile Dysfunction	$ 3,392.41	323	30	$ 10.50	$ 113.08
Pharmacy	Temozolomide	Oncology	$ 371.86	1	1	$ 371.86	$ 371.86
Pharmacy	Tenofovir Disoproxil Fumarate	HIV	$ 416.49	15	3	$ 27.77	$ 138.83
Pharmacy	Testosterone	Endocrine Disorder	$ 35,721.41	323	42	$ 110.59	$ 850.51
Pharmacy	Toremifene Citrate	Oncology	$ 17,228.64	24	1	$ 717.86	$ 17,228.64
Pharmacy	Trametinib Dimethyl Sulfoxide	Oncology	$ 210,289.81	16	2	$ 13,143.11	$ 105,144.91
Pharmacy	Tranexamic Acid	Hemophilia	$ 2,886.73	44	23	$ 65.61	$ 125.51
Pharmacy	Travoprost	Ophthalmic Conditions	$ 11,611.56	138	15	$ 84.14	$ 774.10
Pharmacy	Triamcinolone Acetonide	Osteoarthritis	$ 22.90	2	2	$ 11.45	$ 11.45
Pharmacy	Trifluridine-Tipiracil	Oncology	$ 15,919.30	1	1	$ 15,919.30	$ 15,919.30
Pharmacy	Valganciclovir HCl	Transplant	$ 14,704.66	78	11	$ 188.52	$ 1,336.79
Pharmacy	Venetoclax	Oncology	$ 119,185.87	16	2	$ 7,449.12	$ 59,592.94
Pharmacy	Zidovudine	HIV	$ 6.09	1	1	$ 6.09	$ 6.09
Pharmacy	Zoledronic Acid	Osteoporosis	$ 121.00	1	1	$ 121.00	$ 121.00
Rural Health Clinic	Ketorolac Tromethamine	Miscellaneous Specialty Condit	$ 14.14	6	5	$ 2.36	$ 2.83
Rural Health Clinic	Triamcinolone Acetonide	Osteoarthritis	$ 30.08	5	4	$ 6.02	$ 7.52
Skilled Nursing Facility	Ketorolac Tromethamine	Miscellaneous Specialty Condit	$ 19.00	1	1	$ 19.00	$ 19.00
Unknown	Azacitidine	Oncology	$ 8,757.17	30	2	$ 291.91	$ 4,378.59
Unknown	Bortezomib	Oncology	$ 72,040.00	16	2	$ 4,502.50	$ 36,020.00
Unknown	Carmustine	Oncology	$ 5,996.42	1	1	$ 5,996.42	$ 5,996.42
Unknown	Cytarabine	Oncology	$ 238.50	1	1	$ 238.50	$ 238.50
Unknown	Daratumumab-Hyaluronidase-fihj	Oncology	$ 183,643.91	12	2	$ 15,303.66	$ 91,821.96
Unknown	Etoposide	Oncology	$ 251.75	1	1	$ 251.75	$ 251.75
Unknown	Ketorolac Tromethamine	Miscellaneous Specialty Condit	$ 36.57	1	1	$ 36.57	$ 36.57
Unknown	Methotrexate Sodium	Inflammatory Conditions	$ 93.07	1	1	$ 93.07	$ 93.07
Unknown	Mycophenolate Mofetil	Transplant	$ 121.85	3	2	$ 40.62	$ 60.93
Unknown	Mycophenolate Sodium	Transplant	$ 3,787.55	14	3	$ 270.54	$ 1,262.52
Unknown	Zoledronic Acid	Osteoporosis	$ 1,271.09	4	3	$ 317.77	$ 423.70
Urgent Care Facility	Ketorolac Tromethamine	Miscellaneous Specialty Condit	$ 151.98	124	113	$ 1.23	$ 1.34
Urgent Care Facility	Sumatriptan Succinate	Miscellaneous Specialty Condit	$ 200.00	1	1	$ 200.00	$ 200.00
Urgent Care Facility	Triamcinolone Acetonide	Osteoarthritis	$ 24.34	5	5	$ 4.87	$ 4.87
Walk-in Retail Health Clinic	Triamcinolone Acetonide	Osteoarthritis	$ 4.48	1	1	$ 4.48	$ 4.48
		Totals	**$ 20,952,953.58**	**38,728**			

EXHIBIT 4

Possible duplication of claims

Comments	Carrier	Clm Type	clmtId	Incurred Date	Route Admin	ServiceCode	ServiceDesc	gpi10Desc	ChargeAmt	AllowedAmt	DeductAmt	CopayCoins	PaidAmt	PrescriberNo	ProviderNo	ProviderName	POS	POSDescription	Qty	DaysSupply
Yes, duplicate. Should need two different IUD within such a short timeframe.	NVSOM	P	[redacted]	2/27/2023	IU	50419042301	MIRENA IUD SYSTEM	Levonorgestrel (IUD)	$ -	$ 1,053.92	$ -	$ -	$1,053.92	1366593345	1174546857	HEALTH SERVICE PHARMACY UNI OF MT		Pharmacy	1.000	30
Yes, duplicate. Should need two different IUD within such a short timeframe.	BCBSMT	M	[redacted]	3/2/2023		J7296	Levonorgestrel-releasing intrauterine contraceptive system, (Kyleena), 19.5 mg	Levonorgestrel (IUD)	$ 1,549.00	$ 1,134.75	$ -	$ -	$1,134.75		0000MT0002997		11	Office	1.000	0
[redacted]																				
Yes, duplication. Injection is once every 4 weeks	NVSOM	P	[redacted]	11/2/2022	IM	65757030001	VIVITROL INJ 380MG	Naltrexone	$ -	$ 1,440.70	$ -	$ 500.00	$ 940.70	1205089588	1386932382	ST PETERS HEALTH BROADWAY PHARMACY		Pharmacy	1.000	28
Yes, duplication. Injection is once every 4 weeks	ALLEGIANCE	M	[redacted]	11/3/2022		J2315	NALTREXONE, DEPOT FORM	Naltrexone	$ 2,097.60	$ 1,622.60	$ -	$ 308.23	$1,314.37		810233121594	MEGAN S ZAWACKI PAC	11	Office	380.000	0
Yes, duplication. Injection is once every 4 weeks	NVSOM	P	[redacted]	12/1/2022	IM	65757030001	VIVITROL INJ 380MG	Naltrexone	$ -	$ 1,440.70	$ -	$ 500.00	$ 940.70	1205089588	1386932382	ST PETERS HEALTH BROADWAY PHARMACY		Pharmacy	1.000	27
Yes, duplication. Injection is once every 4 weeks	ALLEGIANCE	M	[redacted]	12/1/2022		J2315	NALTREXONE, DEPOT FORM	Naltrexone	$ 2,097.60	$ 1,622.60	$ -	$ -	$1,622.60		810233121601	KYLE V MOORE MD	11	Office	380.000	0
[redacted]																				

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This document has been prepared in good faith on the basis of information provided to Claim Technologies Incorporated, without any independent verification. If the data, information, and observations received are inaccurate or incomplete, our review, analysis, and conclusions may likewise be inaccurate or incomplete. Our conclusions and recommendations are developed after careful analysis and reflect our best professional judgment.

Claim Technologies Incorporated representatives may from time to time provide observations regarding certain tax and legal requirements including the requirements of federal and state health care reform legislation. These observations are based on our good-faith interpretation of laws and regulations currently in effect and are not intended to be a substitute for legal or tax advice. Please contact your legal counsel and tax accountant for advice regarding legal and tax requirements.

CLAIM TECHNOLOGIES INCORPORATED

PART OF THE BROWN & BROWN TEAM

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DENTAL

LEGISLATIVE AUDIT DIVISION

Angus Maciver, Legislative Auditor
Kenneth E. Varns, Legal Counsel

Deputy Legislative Auditors:
Cindy Jorgenson
William Soller
Miki Cestnik

June 2024

The Legislative Audit Committee
of the Montana State Legislature:

Enclosed is the report on the claim audit of the state of Montana employee dental benefits plan administered by Delta Dental for the calendar years 2022 and 2023.

The audit was conducted by Claim Technologies Incorporated, part of Brown & Brown, under a contract between the firm and our office. The comments and recommendations contained in this report represent the views of the firm and not necessarily the Legislative Auditor.

The agency's written response to the report recommendations is included in the back of each report.

Respectfully submitted,

/s/ Angus Maciver

Angus Maciver
Legislative Auditor

23C-09

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Comprehensive Claim Administration Audit

EXECUTIVE SUMMARY REPORT

State of Montana Dental Plans

Administered by Delta Dental of Montana

Audit Period: January 1, 2022 through December 31, 2023

Presented to

State of Montana

September 2024

CLAIM TECHNOLOGIES INCORPORATED

PART OF THE BROWN & BROWN TEAM

Proprietary and Confidential

TABLE OF CONTENTS

INTRODUCTION

This ***Executive Summary*** contains CTI's findings and recommendations from our audit of Delta Dental of Montana's (Delta Dental) administration of the dental plan managed by the Health Care and Benefits Division within the Montana Department of Administration and subject to the oversight of the State of Montana Legislative Audit Division (the State). You can review the detail that supports CTI's findings and recommendations in our ***Specific Findings Report***.

CTI specializes in the audit and control of health plan claim administration. Accordingly, the statements we make relate narrowly and specifically to the overall effectiveness of policies, procedures, and systems Delta Dental used to pay the State's claims during the audit period.

CTI conducted the audit according to accepted standards and procedures for claim audits in the health insurance industry. We based our audit findings on the data and documentation provided by the State and Delta Dental. The validity of our findings relies on the accuracy and completeness of that information. We planned and performed the audit to gain reasonable assurance claims were adjudicated consistently and accurately in relationship to the policy provisions and administrative agreement between the State and Delta Dental. As required by the State, a draft of this report was also reviewed by certified public accountant, Nick George, of Brown & Brown Insurance. While he did not review source documentation, no exceptions to our findings were noted.

While performing the audit, CTI complied with all confidentiality, non-disclosure, and conflict of interest requirements and did not receive anything of value or any benefit of any kind other than agreed upon audit fees.

OBJECTIVES AND SCOPE

The objectives of CTI's audit of Delta Dental's claim administration were to determine whether:

- Delta Dental followed the terms of its contract with the State;
- Delta Dental paid claims according to the provisions of the plan documents and if those provisions were clear and consistent;
- members were eligible and covered by the State's plans at the time a service paid by Delta Dental was incurred; and
- any claim administration or processes need improvement.

CTI audited Delta Dental's claim administration of the State dental plans for the period of January 1, 2022 through December 31, 2023. The population of claims and amount paid during that period were:

Total Paid Amount	$13,808,613
Total Number of Claims Paid/Denied/Adjusted	95,163

The audit included the following components which are described in greater detail on the following pages:

- Random Sample Audit of 110 Claims
- 100% Electronic Screening with 15 Targeted Samples
- Operational Review and Questionnaire
- Plan Documentation Analysis

AUDIT FINDINGS AND RECOMMENDATIONS

Random Sample Findings

CTI validated claim processing accuracy based on a sample of 110 dental claims paid or denied by Delta Dental during the audit period. We selected the random sample (stratified by the claim billed amount) to provide a statistical confidence level of 95% +/- 3% margin of error.

CTI's Random Sample Audit categorizes errors into key performance indicators. We use this systematic labeling of errors and calculation of performance as the basis for the benchmarks generated using results from our most recent 40 dental claim audits.

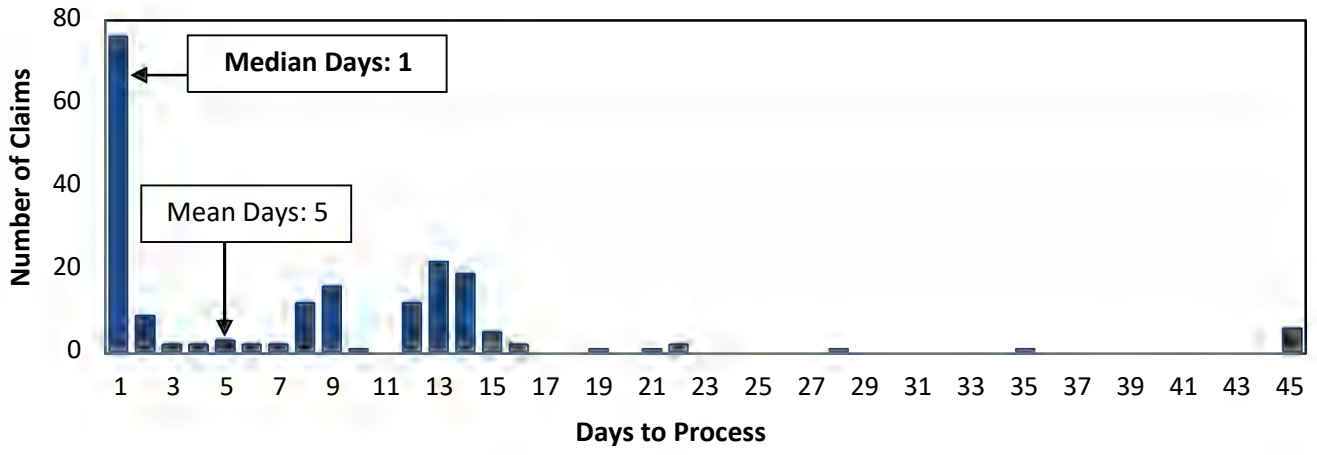
The following table illustrates Delta Dental's performance was above the median in all three of CTI's benchmarked performance indicators and that there were no errors cited in our Random Sample audit.

Key Performance Indicators	Administrator's Performance by Quartile				
	Quartile 1	Quartile 2	MEDIAN	Quartile 3	Quartile 4
	Lowest →				*Highest*
Financial Accuracy: Compares total dollars associated with correct claim payments to total dollars of correct claim payments that should have been made.			**99.85%**		**100%**
Accurate Payment: Compares number of correctly paid claims to total number of claims paid.			**99.09%**		**100%**
Accurate Processing: Compares number of claims processed without any type of error (financial or non-financial) to total number of claims processed.			**98.99%**		**100%**

Claim Turnaround Time

A final measure of claim administration performance is claim turnaround time. Through the audit sample, Delta Dental demonstrated its median turnaround time on a complete claim submission was 1 day from the date it received a complete claim to the date the claim was paid or denied.

Median and Mean Claim Turnaround



Random Sample Recommendation

Delta performed at a very high level during the audit period. However, CTI did cite one additional observation. CTI recommends the State discuss with Delta Dental its review process for possible cosmetic procedures to ensure it is in alignment with the plan's intent. Our auditor identified a member who had a composite filling on the facial surface of six anterior teeth without a review for the possibility of cosmetic procedure. CTI also recommends continued audit and review of Delta Dental to ensure it maintains the high level of performance demonstrated during this audit.

100% Electronic Screening with Targeted Samples Findings

We used our proprietary Electronic Screening and Analysis System (ESAS) software to further analyze claim payment accuracy as well as any opportunities for system and process improvement. Using the data file provided by Delta Dental, we adjudicated each line on every claim the plan paid or denied during the audit period against the plan's benefits. Our Technical Lead Auditor tested a targeted sample of 15 claims to provide insight into Delta Dental's claim administration as well as operational policies and procedures.

The following table shows the dental services identified as potentially overpaid. It is important to note that the amount shown represents potential payment errors; additional testing would be required to substantiate the findings and provide the basis for remedial action planning or recovery.

ESAS Candidates for Additional Testing	Paid/At Risk
Duplicate Payments	**$40,045**
Plan Limitations – Routine Prophylaxis Two Times Per Plan Year	**$242**
Plan Exclusions	**$48,171**
Oral Examinations	$24,180
Other Surgical Procedures	$23,897
Periodontics	$94

For specific information on the over and underpayments identified, see the ESAS section of CTI's ***Specific Findings Report***.

100% Electronic Screening with Targeted Samples Recommendations

The State should discuss the five errors identified via ESAS with Delta Dental. One error was manual, made by a claim processor and should be addressed through coaching and counseling. For the remining four errors, Delta should determine the root cause of the errors to identify other claims that may have been affected. CTI can prepare claim detail for Delta Dental to use in its analysis.

Operational Review Findings

Delta Dental completed our Operational Review Questionnaire and provided information on its:

- Systems, staffing, and workflow;
- Claim administration and eligibility maintenance procedures; and
- Internal control risk mechanisms, e.g., HIPAA protections; internal audit policies and practices; and fraud, waste, and abuse detection and prevention.

Our Operational Review indicated:

- Delta Dental had performance guarantees with the State for the following globally reported measures based on their entire book of business: Claim Turnaround, Overall Claim Accuracy, Customer Service, and Provider Monitoring. Delta Dental also had state-specific guarantees for Account Management, Network Contract Guarantee, Timely Reporting, and Claim File Transfers. The report provided by Delta Dental showed all performance guarantees were met in 2023.
- Delta Dental did not provide dedicated claim or customer service personnel to the State, although a Sales Account Executive and Account Manager have overall responsibility for the State's account.
- Delta Dental had a Business Continuity and Disaster Recovery program that was fully documented and tested at least annually. In the event of a disaster, customer-facing systems such as telephone, web, and email were recovered in as little as 12 hours, core claims processing systems were recovered within 24 hours, and peripheral work and reporting systems were recovered within 72 hours.
- Delta Dental indicated when claims adjustments were performed within the claim system, all self-funded clients were automatically credited under weekly claims billing. If unable to collect, it became a Delta Dental expense without any impact to the client. In addition, it can recoup from future payments to a network provider.
- Delta Dental complied with state laws requiring escheat of unclaimed checks.
- Delta Dental's systems required security for ID and passwords. Passwords were changed automatically every 30 days. Access to the system required approval by the employee's manager and was granted based on role and business requirements described in the employee's job description.
- Claims examiners were not allowed to override any system-applied codes which required dental determination. Group benefits could not be overridden, and a dental consultant gave approval for an override of claims that required additional review.
- Through an automated assignment of benefits process, Delta Dental allowed assignment of benefits for non-network providers. CTI notes this practice is an effective way to guard against fraudulent claim payments that would otherwise be made directly to members.
- Delta Dental had adequately documented training, workflow, procedures, and systems to provide consistently high levels of accuracy in the processing of claims and enrollment.
- Claims that required analysis or more complicated decision-making were handled by more experienced examiners. Claims that required review by a dental consultant were typically the last stop in claims processing. Delta Dental conducted daily internal performance management audits on about 5% of all claims handled directly by claims examiners. Feedback regarding errors was given to the individual examiner who made the error.
- Delta Dental reported coordination of benefits (COB) savings of $77,390 for the period of December 2021 through December 2022 and $75,020 for the period of December 2022 through December 2023.

- Delta Dental had no minimum amount below which recovery of overpayments was not attempted. Overpayments to participating dentists were withheld from future checks.
- During the calendar year 2023, 54 appeals were filed with 41 (75.93%) of those resolved in favor of Delta Dental, upholding the original claim determination.
- Delta Dental's Network Oversight and Compliance department conducted onsite examinations of dental offices to ensure member dentists were abiding by the terms of their agreements with Delta Dental and investigated allegations of fraud.
- Between June 1, 2022 and May 31, 2023, Delta Dental reported it preliminarily investigated 1,045 potential fraud matters; 164 cases were opened as investigations, 214 cases were closed (cases opened in previous years were included in this number), and 119 were referrals to law enforcement.
- Delta Dental indicated it used state and federal databases to screen for providers who have been sanctioned by government programs. CTI screened 100% of non-facility claims against the Office of Inspector General's List of Excluded Individuals and Entities and there were no claims paid to providers on the list.
- Delta Dental used internal tools to identify dentists who, when compared to peer group norms, were most likely engaging in questionable activities. Delta Dental's systems enhanced fraud-detection activities provided information for practice intervention efforts directed at individual dentists. This helped Delta Dental manage utilization within its network of dentists and protects clients from potential abuse.
- Delta Dental indicated 71.6% of claims came from network dentists but declined to provide a report showing discounts obtained from providers during the audit period.
- CTI was unable to calculate provider discounts for the State because Delta Dental considers contracted discounts confidential information and did not provide them in electronic format.
- Delta Dental reimbursed dentists based on Maximum Contract Allowances (MCA) based on a review of claim charges submitted on a regional basis for a given service by dentists of similar training within the same geographical area. Fees were reviewed at least annually.
- Delta Dental used full-time dental consultants for claim review, pre-treatment estimate review, and quality assessments. These individuals have a DDS/DMD degree, active licenses and at least five years' experience. Consultants attended continuing education and must maintain an active license.
- All Delta Dental employees were required to complete compliance training within 30 days of their hire date and annually thereafter.
- Delta Dental self-reported a breach of members' information triggering notification requirements during the audit period. On June 1, 2023, Delta Dental was notified of a breach that occurred between May 27, 2023 and May 30, 2023. In addition, there was one other breach that affected two of the State's members due to a contractor emailing an EOB to another member inadvertently. The State was made aware of this breach as well.

Operational Review Recommendations

CTI recommends the State should consider requesting:

- Delta Dental provide results of its performance guarantees that are specific to the State going forward as results for the audit period were reported at a global, book of business level.
- Delta Dental provide sufficient detail in the claim file provided to its auditor to allow for independent validation of self-reported provider discounts.

Plan Documentation Analysis Findings and Recommendations

CTI observed a conflict between the 2022 and 2023 Summary Plan Description (SPD) regarding bitewing x-rays.

- The 2022 SPD shows on page 5 of Appendix C that bitewing x-rays fall under limitations on diagnostic and preventive benefits. This indicates no member cost-share would apply.
- The 2023 SPD shows on page 7 of Appendix C that bitewing x-rays moved to limitations on basic benefits. This indicates member cost share would apply.

After discussion with both the State and Delta Dental, CTI recommends the SPD be updated as plan intent was for bitewing x-rays to remain under limitations on diagnostic and preventive benefits with no member cost-share.

CONCLUSION

We understand you will need to review these findings and recommendations to determine your priorities for action. Should the State desire additional assistance with this, our contract offers eight hours of post-audit time to help you create an implementation plan.

CTI also suggests that the State perform a follow-up audit to verify that Delta Dental has made the recommended improvements, that performance results against benchmarks are improving, and that no new processing issues have arisen.

We consider it a privilege to have worked with the State and your staff. We welcome any opportunity to assist you in the future. Thank you again for choosing CTI.

CLAIM TECHNOLOGIES INCORPORATED

PART OF THE BROWN & BROWN TEAM

100 Court Avenue – Suite 306 • Des Moines, IA 50309
(515) 244-7322 • claimtechnologies.com

Comprehensive Claim Administration Audit

SPECIFIC FINDINGS REPORT

State of Montana Dental Plans

Administered by Delta Dental of Montana

Audit Period: January 1, 2022 through December 31, 2023

Presented to

State of Montana

September 2024

CLAIM TECHNOLOGIES INCORPORATED

PART OF THE BROWN & BROWN TEAM

Proprietary and Confidential

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INTRODUCTION

This ***Specific Findings Report*** contains CTI's findings and recommendations from our audit of Delta Dental of Montana's (Delta Dental) administration of the dental plan managed by the Health Care and Benefits Division within the Montana Department of Administration and subject to the oversight of the State of Montana Legislative Audit Division (the State). The statistics, observations, and findings in this report constitute the basis for the analysis and recommendations presented under separate cover in the ***Executive Summary***. We provide this report to the State, the plan sponsor, and Delta Dental, the claims administrator. A copy of Delta Dental's response to these findings can be found in Appendix B of this report.

CTI specializes in the audit and control of health plan claim administration. Accordingly, the statements we make relate narrowly and specifically to the overall effectiveness of policies, procedures, and systems Delta Dental used to pay the State's claims during the audit period.

CTI conducted the audit according to accepted standards and procedures for claim audits in the health insurance industry. We based our audit findings on the data and documentation provided by the State and Delta Dental. The validity of our findings relies on the accuracy and completeness of that information. We planned and performed the audit to gain reasonable assurance claims were adjudicated consistently and accurately in relationship to the policy provisions and administrative agreement between the State and Delta Dental. As required by the State, a draft of this report was also reviewed by certified public accountant, Nick George, of Brown & Brown Insurance. While he did not review source documentation, no exceptions to our findings were noted.

While performing the audit, CTI complied with all confidentiality, non-disclosure, and conflict of interest requirements and did not receive anything of value or any benefit of any kind other than agreed upon audit fees.

Audit Objectives

The objectives of CTI's audit of Delta Dental's claim administration were to determine whether:

- Delta Dental followed the terms of its contract with the State;
- Delta Dental paid claims according to the provisions of the plan documents and if those provisions were clear and consistent;
- members were eligible and covered by the State's plans at the time a service paid by Delta Dental was incurred; and
- any claim administration systems or processes need improvement.

Audit Scope

CTI audited Delta Dental's claim administration of the State dental plans for the period of January 1, 2022 through December 31, 2023. The population of claims and amount paid during that period were:

Total Paid Amount	$13,808,613
Total Number of Claims Paid/Denied/Adjusted	95,163

The audit included the following components:

1. **Operational Review**
    - Claim administrator information
    - Claim administrator claim fund account
    - Claim adjudication and eligibility maintenance procedures
    - HIPAA compliance

2. **Plan Documentation Analysis**
    - Plan documents and other approved communications
    - Identify missing provisions, ambiguities, and inconsistencies
    - Administrative services agreement

3. **100% Electronic Screening with 15 Targeted Samples**
    - Systematic analysis of 100% of paid claims
    - Problem identification and quantification

4. **Random Sample Audit of 110 Claims**
    - Statistical confidence at 95% +/- 3%
    - Key Indicator performance levels
    - Benchmarking
    - Identify and prioritize problems

OPERATIONAL REVIEW

Objective

CTI's Operational Review evaluates Delta Dental's claim administration systems, staffing, and procedures to identify any deficiencies that materially affect its ability to control risk and pay claims accurately on behalf of the plans.

Scope

The scope of the Operational Review included:

- Claim administrator information
  - Insurance and bonding
  - Conflicts of interest
  - Financial reporting
  - Business continuity planning
  - Claim payment system and coding protocols
  - Data and system security
- Claim funding
  - Claim funding mechanism
  - Check processing and security
  - Large claim payment process
- Claim adjudication, customer service, and eligibility maintenance procedures
  - Exception claim processing
  - Eligibility maintenance and investigation
  - Overpayment recovery
  - Network utilization
  - Appeals processing
- HIPAA compliance

Methodology

CTI used an Operational Review Questionnaire to gather information from Delta Dental. We modeled our questionnaire after the audit tool used by certified public accounting firms when conducting an SSAE 21 or Systems and Organization Controls (SOC) audit of a service administrator. We modified that tool to elicit information specific to the administration of your plans.

We reviewed Delta Dental's responses and any supporting documentation supplied to gain an understanding of the procedures, staffing, and systems used to administer the State's plans. This allowed us to conduct the audit more effectively.

Findings

We observed the following:

- Delta Dental provided certificates of insurance that showed it maintained levels and types of insurance reasonable and customary for a health services organization with comparable size and market presence.
- Delta Dental had performance guarantees with the State for the following globally reported measures based on their entire book of business: Claim Turnaround, Overall Claim Accuracy, Customer Service, and Provider Monitoring. Delta Dental also had state-specific guarantees for Account Management, Network Contract Guarantee, Timely Reporting, and Claim File Transfers. Review of the reports provided by Delta Dental showed all performance guarantees were met in 2022 and 2023.
- Delta Dental provided a copy of its System and Organization Controls (SOC) 2 Type 2 Report on the Security, Availability, Confidentiality, Processing Integrity, and Private Trust Services Categories (the Report) for the period of January 1, 2023 through December 31, 2023 issued by its external auditor Armanino LLC. The report was issued in accordance with the requirements of the American Institute of Certified Public Accountants (AICPA). Armanino performed various testing procedures against the internal controls identified by Delta Dental in the following areas:
    - Control Environment
    - Communication and Information
    - Risk Assessment
    - Monitoring Activities
    - Control Activities
    - Logical and Physical Access Controls
    - System Operations
    - Change Management
    - Risk Mitigation
- Delta Dental did not provide dedicated claim or customer service personnel to the State, although a Sales Account Executive and Account Manager have overall responsibility for the State's account.
- Delta Dental used the MetaVance claims processing system, a common platform used throughout the dental insurance industry. Business intelligence and reporting software were used within the system to identify billing and utilization patterns that were specific to procedures most likely to be up coded.
- Delta Dental had a Business Continuity and Disaster Recovery program that was fully documented and tested at least annually. In the event of a disaster, customer-facing systems such as telephone, web, and email were recovered in as little as 12 hours, core claims processing systems were recovered within 24 hours, and peripheral work and reporting systems were recovered within 72 hours.
- Delta Dental indicated when claims adjustments were performed within the claim system, all self-funded clients were automatically credited under weekly claims billing. If unable to collect,

it became a Delta Dental expense without any impact to the client. In addition, it can recoup from future payments to a network provider.

- Delta Dental complied with state laws requiring escheat of unclaimed checks.
- Delta Dental's systems required security for ID and passwords. Passwords were changed automatically every 30 days. Access to the system required approval by the employee's manager and was granted based on role and business requirements described in the employee's job description.
- Claims examiners were not allowed to override any system-applied codes which required dental determination. Group benefits could not be overridden, and a dental consultant gave approval for an override of claims that required additional review.
- Through an automated assignment of benefits process, Delta Dental allowed assignment of benefits for non-network providers. CTI notes this practice is an effective way to guard against fraudulent claim payments that would otherwise be made directly to members.
- Delta Dental had adequately documented training, workflow, procedures, and systems to provide consistently high levels of accuracy in the processing of claims and enrollment.
- Claims that required analysis or more complicated decision-making were handled by more experienced examiners. Claims that required review by a dental consultant were typically the last stop in claims processing. Delta Dental conducted daily internal performance management audits on about 5% of all claims handled directly by claims examiners. Feedback regarding errors was given to the individual examiner who made the error.
- Eligibility updates for the State were processed on a bi-weekly basis, on Wednesdays. Dependent eligibility was handled by the State.
- Delta Dental collected coordination of benefits (COB) information at the time of enrollment and accepted updates at any time. Claims with missing COB information were denied and both the dentist and the member were asked to resubmit the claim with the correct information. If a claim was processed and it was later discovered there was other coverage, Delta Dental pursued the overpayment.
- Delta Dental followed industry standard COB processing to ensure combined benefits from all of a members' benefit plan will not exceed 100% of the amount Delta Dental determines to be the total covered expense. Delta Dental used the birthday rule in determining primacy of coverage for dependents.
- Delta Dental reported COB savings of $77,390 for the period of December 2021 through December 2022 and $75,020 for the period of December 2022 through December 2023.
- 85.2% of Delta Dental claims were submitted electronically and more than 94% auto-adjudicated without human intervention before payment or denial.
- Delta Dental had no minimum amount below which recovery of overpayments was not attempted. Overpayments to participating dentists were withheld from future checks.
- Delta Dental did not provide overpayment reports. All self-funded clients were automatically credited for claim adjustments on a weekly basis.

- During the calendar year 2023, 54 appeals were filed with 41 (75.93%) of those resolved in favor of Delta Dental, upholding the original claim determination.
- Delta Dental's Network Oversight and Compliance department conducted onsite examinations of dental offices to ensure member dentists were abiding by the terms of their agreements with Delta Dental and investigated allegations of fraud.
- Between June 1, 2022 and May 31, 2023, Delta Dental reported it preliminarily investigated 1,045 potential fraud matters; 164 cases were opened as investigations, 214 cases were closed (cases opened in previous years were included in this number), and 119 were referrals to law enforcement.
- Delta Dental indicated it used state and federal databases to screen for providers who have been sanctioned by government programs. CTI screened 100% of non-facility claims against the Office of Inspector General's List of Excluded Individuals and Entities and there were no claims paid to providers on the list.
- Delta Dental used internal tools to identify dentists who, when compared to peer group norms, were most likely engaging in questionable activities. Delta Dental's systems enhanced fraud-detection activities provided information for practice intervention efforts directed at individual dentists. This helped Delta Dental manage utilization within its network of dentists and protects clients from potential abuse.
- Delta Dental indicated 71.6% of claims came from network dentists but declined to provide a report showing discounts obtained from providers during the audit period.
- CTI was unable to calculate provider discounts for the State because Delta Dental considers contracted discounts confidential information and did not provide them in electronic format.
- Delta Dental reimbursed dentists based on Maximum Contract Allowances (MCA) based on a review of claim charges submitted on a regional basis for a given service by dentists of similar training within the same geographical area. Fees were reviewed at least annually.
- Delta Dental used full-time dental consultants for claim review, pre-treatment estimate review and quality assessments. These individuals have a DDS/DMD degree, active licenses and at least five years' experience. Consultants attended continuing education and must maintain an active license.
- Delta Dental had designated compliance with HIPAA and associated regulatory changes as one of its top corporate priorities. Ongoing review of policies and procedures occurred to comply with new laws and regulations.
- All Delta Dental employees were required to complete compliance training within 30 days of their hire date and annually thereafter.
- Delta Dental self-reported a breach of members' information triggering notification requirements during the audit period. On June 1, 2023, Delta Dental was notified of a breach that occurred between May 27, 2023 and May 30, 2023. In addition, there was one other breach that affected two of the State's members due to a contractor emailing an EOB to another member inadvertently. The State was made aware of this breach as well.

PLAN DOCUMENTATION ANALYSIS

Objective

CTI's Plan Documentation Analysis evaluates the documents governing administration of the State's dental plans and identifies inconsistencies, ambiguities, or missing provisions that might negatively impact accurate claim administration. Through this evaluation, we gained an understanding of Delta Dental's administrative service responsibilities for the State's dental plans. This understanding allowed us to audit more effectively.

Scope

Our auditors evaluated the plan documents, summary plan descriptions, and any amendments along with the administrative services agreement.

Methodology

CTI obtained a copy of the plan documentation from the State and/or Delta Dental. Our auditors reviewed the applicable documents to better understand the provisions Delta Dental should have used to process and pay all dental claims. CTI obtained clarification from the State about any inconsistencies in the plan documents. Our auditors referenced these plan documents as they audited claims.

Findings

CTI observed a conflict between the 2022 and 2023 Summary Plan Description (SPD) regarding bitewing x-rays.

- The 2022 SPD shows on page 5 of Appendix C that bitewing x-rays fall under limitations on diagnostic and preventive benefits. This indicates no member cost-share would apply.
- The 2023 SPD shows on page 7 of Appendix C that bitewing x-rays moved to limitations on basic benefits. This indicates member cost share would apply.

After discussion with both the State and Delta Dental, CTI recommends the SPD be updated as plan intent was for bitewing x-rays to remain under limitations on diagnostic and preventive benefits with no member cost-share.

100% ELECTRONIC SCREENING WITH TARGETED SAMPLE ANALYSIS

Objective

CTI's Electronic Screening and Analysis System (ESAS®) software identified and quantified potential claim administration payment errors. The State and Delta Dental should talk about any verified under- or overpayments to determine the appropriate actions to correct any errors.

Scope

CTI electronically screened 100% of the service lines processed by Delta Dental during the audit period. The accuracy and completeness of Delta Dental's data directly impacted the screening categories we completed and the integrity of our findings. We screened the plan data for the following high-level ESAS categories to identify potential amounts at risk:

- Duplicate payments to providers and/or employees
- Plan exclusions and limitations
- Copayments, Deductibles, and Out of Pocket
- Fraud, Waste, and Abuse
- Coordination of benefits

Methodology

We used ESAS to analyze claim payment accuracy as well as any opportunities for system and process improvement. Using the data file provided by Delta Dental, we adjudicated each line on every claim the plan paid or denied during the audit period against the plan's benefits. Our Technical Lead Auditor tested a targeted sample of claims to provide insight into Delta Dental's claim administration as well as operational policies and procedures. We followed these procedures to complete our ESAS process:

- ***Electronic Screening Parameters*** – We relied on the plan document provisions to set the parameters in ESAS.
- ***Data Conversion*** – We converted and validated the claim data and compared it to the control totals provided by the State to check for reasonableness.
- ***Electronic Screening*** – We systematically adjudicated 100% of the service lines processed and flagged claims not administered according to plan parameters.
- ***Auditor Analysis*** – If claims within an ESAS screening category represented a material amount at risk, our auditors analyzed the findings to confirm results were valid. When using ESAS to identify payment errors, note that incomplete claim data could lead to false positives. CTI auditors made every effort to identify and remove false positives.
- ***Targeted Sample Analysis*** – From the categories identified with material amounts at risk, we selected the best examples of potential under- or overpayments to test. As cases were not randomly selected, we did not extrapolate results. We selected up to 15 cases and sent Delta Dental an individual questionnaire for each. Targeted samples helped verify if the claim data supported our finding and if Delta Dental's administration matched the plan's intent.

- ***Audit of Administrator Response and Documentation*** – We reviewed Delta Dental's response and any additional supporting information provided. Based on this information and any additional analysis required, if false positives were identified, we removed the identified claims from the potential amounts at risk.

Findings

While we are confident in the accuracy of our ESAS results, note the dollar amounts associated with the results represent potential payment errors and process improvement opportunities. We would have to perform additional testing to substantiate the findings that could then provide the basis for remedial action planning or reimbursement.

The following report shows, by category, the number of line items or claims and the total potential amount at risk remaining at the conclusion of our analysis, targeted samples, and removal of verified false positives. Following the report is a detailed explanation of our results with findings for all screening categories where process improvement, recovery or savings opportunities exist. The administrator responses are copied directly from Delta Dental's reply to the audit findings.

It is important to note that even if the sampled claim was subsequently corrected prior to CTI's audit, we have still cited the error so you can discuss how to reduce errors and re-work in the future with your administrator.

The amounts shown in the Potential Recovery column was derived from CTI's compilation and summary of the claim data submitted by Delta Dental. The Allowed amount represents the amount allowed after network discounts, usual and customary, or member cost share. The Potential Recovery amount includes overpayments only. Further administrator review would be required to verify the categories in which errors were identified through our analysis to validate the ***Potential Recovery*** amount. This additional layer of review will occur following presentation of audit results and further discussion with the State and Delta Dental.

Recommended Client-Specific ESAS Categories for Additional Testing				
Client: The State **Screening Period:** January 1, 2022 through December 31, 2023				
Category	**Lines**	**Claimants**	**Allowed**	**Potential Recovery**
Duplicate Payments				
Providers and/or Employees	2,902	597	$889,574	$40,045
Plan Limitations				
Routine Prophylaxis Two Times Per Plan Year	12	4	$726	$242
Plan Exclusions				
Oral Examinations	740	511	$41,574	$24,180
Other Surgical Procedures	65	57	$49,314	$23,897
Periodontics	1	1	$155	$94

ESAS Findings Detail Report				
QID	**Under/ Over Paid**	**Delta Dental Response**	**CTI Conclusion**	**Manual or System**
Duplicate Payments				
3	$22.00	Agree. DCN XXXXXXXXXX3709 was received on 11/08/23 and suspended for Other Coverage listed on claim and EOB. In the mean time, DCN XXXXXXXXXX6921 was received and auto adjudicated on 11/09/23. Other coverage was listed on image but the box was not checked that there was other coverage so system did not pick up that they had OIC so it was auto adjudicated. Once DCN XXXXXXXXXX3709 was pulled from the queue and OIC was listed and EOB Provided DCN XXXXXXXXXX6921 was voided and money returned.	Procedural deficiency and overpayment identified. Although corrected prior to audit, a duplicate payment was made on this claim.	☐ M ☒ S
Plan Limitations				
Routine Prophylaxis Two Times Per Plan Year				
4	$33.00	Agree. The member's benefits were exceeded based on the Provider Dispute received. The member had a Kidney Tranplant in 2021 and a third cleaning was recommended to keep good oral hygiene.	Procedural deficiency and overpayment identified. Per page six of the plan document, charges for routine oral examinations and cleanings are covered only twice per year by the plan. Additional follow-up action is required regarding recovery of overpayment.	☐ M ☒ S
Plan Exclusions				
Oral Examination				
11	$21.00	Disagree. This procedure does not require a consultant review.	Procedural deficiency and overpayment identified. Per page eight of the plan document, there is an exclusion for prescribed drugs, medications, pain killers and/or experimental procedures.	☐ M ☒ S
Periodontics				
13	$96.30	Agree. Since this was submitted with a Miscellaneous Procedure Code, the examiners have a Desk Level Procedure that they follow. If they are not able to determine how to process then they route the claim to our Dental Consultants. The consultant will review and determine if it should be allowed or not based on the documentation that was submitted with the claim. In this case the examiner processed the claim. This procedure should have been denied 718 as inclusive with the other procedures on the claim per the Desk Level Procedure	Procedural deficiency and overpayment identified. Sample claim with miscellaneous code was allowed without review. Additional follow-up action is required regarding recovery of overpayment.	☒ M ☐ S
Other Surgical Procedures				
15	$21.00	Disagree. This procedure does not require a consultant review.	Procedural deficiency and overpayment identified. Per page seven of the plan document, there is an exclusion listing services for congenital (hereditary) or developmental (following birth) malformations, etc.	☐ M ☒ S

RANDOM SAMPLE AUDIT

Objectives

The objectives of our Random Sample Audit were to determine if claims were paid according to plan specifications and the administrative agreement, to measure and benchmark process quality, and to prioritize areas of administrative deficiency for further review and remediation.

Scope

CTI's Random Sample Audit included a stratified random sample of 110 paid or denied claims. The statistical confidence level of the audit sample was 95%, with a 3% margin of error. A copy of the Sample Construction and Weighting Methodology Report for the sample is in Appendix A.

Delta Dental's performance was measured using the following key performance indicators:

- Financial Accuracy
- Accurate Payment
- Accurate Processing

We also measured claim turnaround time, a commonly relied upon performance measure.

Methodology

Our Random Sample Audit ensures a high degree of consistency and is based upon the principles of statistical process control with a management philosophy of continuous quality improvement. Our auditors reviewed each sample claim selected to ensure it conformed to plan specifications, agreements, and negotiated discounts. We recorded our findings in our proprietary audit system.

CTI communicated with Delta Dental in writing via system-generated response forms regarding any potential errors or observations. We sent Delta Dental a preliminary report for its review and written response and considered its written response, as found in Appendix B, when producing our final reports.

It is important to note that after receiving and reviewing Delta Dental's response, CTI found no errors in our Random Sample audit.

Findings

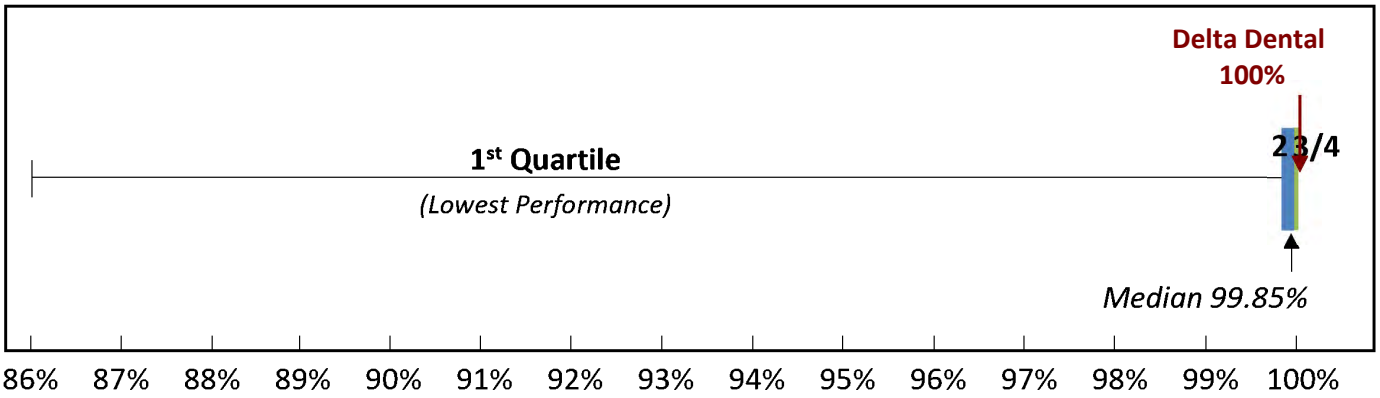
The following box and whiskers charts demonstrate Delta Dental's performance as compared to the last 40 dental audits performed by CTI. The fourth quartile represents the 10 highest performing plans, and the first quartile represents the lowest 10. The Median is the point at which 20 plans audited were above, and 20 plans were below.

Financial Accuracy

CTI defines Financial Accuracy as the total correct claim payments made compared to the total dollars of correct claim payments that should have been made for the audit sample.

The claims sampled and reviewed revealed no underpayments or overpayments, for a combined variance of $0. The payment total for sampled claims was $48,637.60.

The weighted Financial Accuracy rate was 100%.

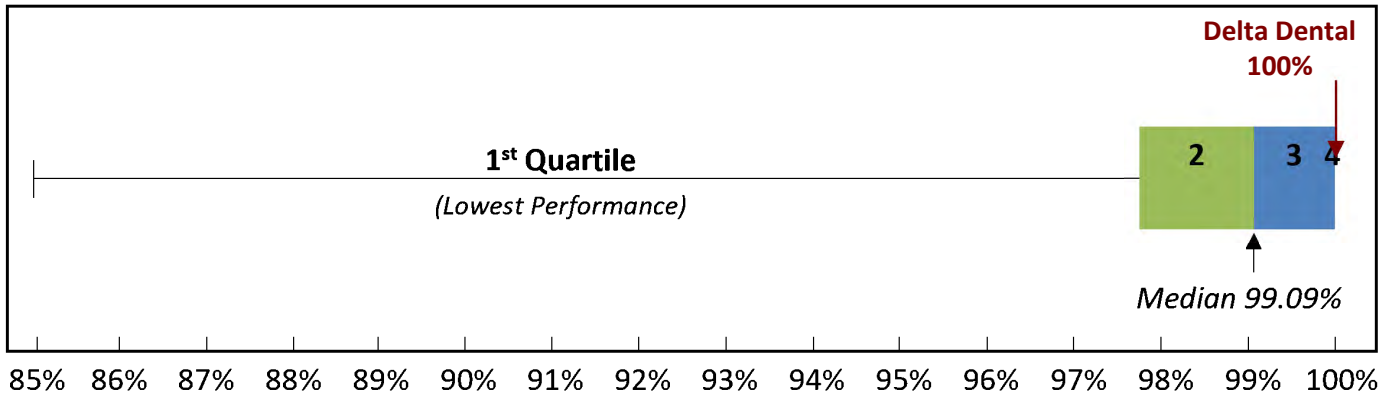


Accurate Payment Frequency

CTI defines Accurate Payment Frequency as the number of claims paid correctly compared to the total number of claims paid for the audit sample.

The audit sample revealed no incorrectly paid claims and 110 correctly paid claims.

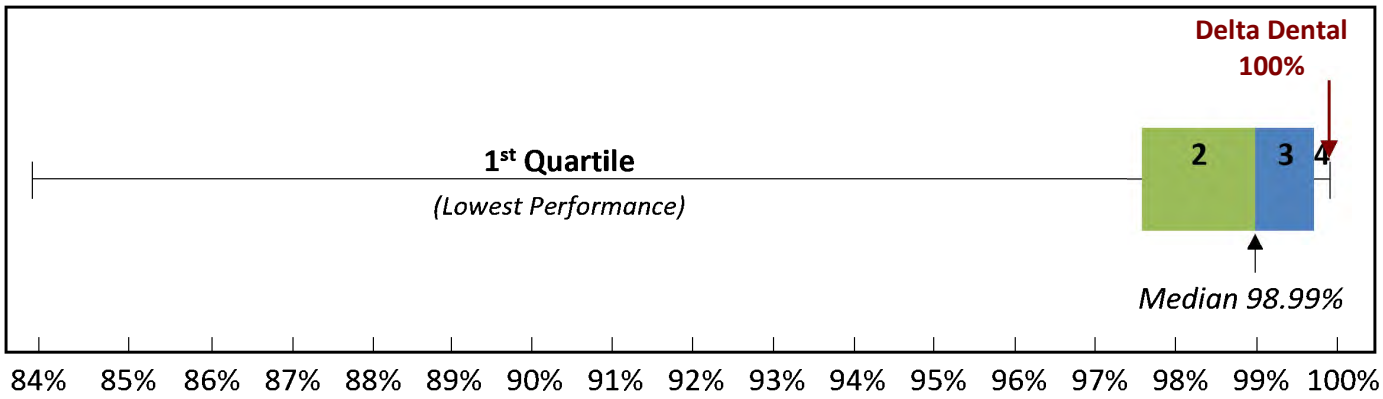
Total Claims	Incorrectly Paid Claims		Frequency
	Underpaid	Overpaid	
110	0	0	100%



Accurate Processing Frequency

CTI defines Accurate Processing Frequency as the number of claims processed without errors compared to the total number of claims processed in the audit sample. When a claim had errors that applied in more than one category, it was counted only once as a single incorrect claim for this measure.

Correctly Processed Claims	Incorrectly Processed Claims		Frequency
	System	Manual	
110	0	0	100%



Claim Turnaround

CTI defines Claim Turnaround as the number of calendar days required to process a claim – from the date the claim was received by the administrator to the date a payment, denial, or additional information request was processed – expressed as both the Median and Mean for the audit sample.

Claim administrators commonly measure claim turnaround time in mean days. Median days, however, is a more meaningful measure for administrators to focus on when analyzing claim turnaround because it prevents one or just a few claims with extended turnaround time from distorting the true performance picture.

Median	Mean	+45 Days to Process
1	5	1

Additional Observations

During the Random Sample Audit, our auditor observed the following procedures or situations that may not have caused an error on the sampled claim but may impact future claims or overall quality of service.

Observation	Audit Number
CTI would like the State to be aware the member in this sampled claim got a composite filling on the facial surface of six anterior teeth without review for possible cosmetic procedure.	1063

CONCLUSION

We consider it a privilege to have worked for, and with, your staff and administrator. Our contract offers eight hours of post-audit time to help you develop an implementation plan should the State desire additional assistance in that regard.

Thank you again for choosing CTI.

APPENDIX A – SAMPLE CONSTRUCTION AND WEIGHTING METHODOLOGY

Client: MTDen23
Audit Period: January 01, 2022 - December 31, 2023

Claim Universe (as converted)

Stratum		Claim Count	Total Charge Amount	Total Paid Amount
<=250	1	84,844	$22,427,917	$8,280,228
<=500	2	6,044	$6,133,526	$2,181,045
>500	3	4,275	$9,447,885	$3,347,340
	Totals	95,163	$38,009,328	$13,808,613

Audit Stratification

Stratum		Audit Universe (# Claims)	Proportion (Weight by Count)	Sample
<=250	1	84,844	89.16%	36
<=500	2	6,044	6.35%	36
>500	3	4,275	4.49%	38
	Totals	95,163	100.00%	110

Audit Sample Overview

Category	Count	Paid Amount
Claims requested for audit	110	$48,637.60
Claims for which records not received	0	$0.00
Claims outside scope of audit	0	$0.00
Claims as entered included in audit sample	110	$48,637.60
Audit sample if all claims paid correctly	110	$48,637.60
Claims with inadequate documentation	0	$0.00
Total claim payments remaining in audit sample	110	$48,637.60

APPENDIX B – ADMINISTRATOR RESPONSE TO DRAFT REPORT

Please note that any additional information submitted to CTI in response to the draft report from the administrator is reviewed, and observations may be removed prior to the final report being published. While a removed observation will not be included in the final report, it may be referenced in the administrator's response that follows.

DELTA DENTAL

deltadentalins.com

April 15, 2024

Ms. Deb Danilson
Claim Technologies Incorporated
100 Court Ave, Suite 306
Deso Moines, IA 50309

Re: State of Montana Claims Audit of Delta Dental

Dear Deb:

Thank you for providing the audit findings for our mutual customer, State of Montana.

State of Montana is a valued customer of Delta Dental. We are committed to administering their benefits accurately and according to their contract. We have reviewed the audit report thoroughly and confirmed that CTI has captured all of Delta Dental's responses.

We look forward to jointly discussing the results of this audit at a future meeting with the State of Montana. Once again, thank you for your partnership.

Sincerely,

Jeffrey Almonte
Senior Regulatory & Group Exam Analyst

Brittany Chandler
Account Manager

Delta Dental Insurance Company (West)

406-449-6270
deltadentalins.com

Offices in Louisiana, Montana, Texas and Utah

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Miki Cestnik

June 2024

The Legislative Audit Committee
of the Montana State Legislature:

Enclosed is the report on the claim audit of the state of Montana employee vision plan administered by VSP vision for the calendar year 2023.

The audit was conducted by Claim Technologies Incorporated, part of Brown & Brown, under a contract between the firm and our office. The comments and recommendations contained in this report represent the views of the firm and not necessarily the Legislative Auditor.

The agency's written response to the report recommendations is included in the back of each report.

Respectfully submitted,

/s/ Angus Maciver

Angus Maciver
Legislative Auditor

23C-09

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Comprehensive Claim Administration Audit

EXECUTIVE SUMMARY REPORT

State of Montana Vision Plan

Administered by VSP Vision Care

Audit Period: January 1, 2023 through December 31, 2023

Presented to

State of Montana

September 2024

CLAIM TECHNOLOGIES INCORPORATED

PART OF THE BROWN & BROWN TEAM

Proprietary and Confidential

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INTRODUCTION

This ***Executive Summary*** contains CTI's findings and recommendations from our audit of VSP Vision Care's (VSP) administration of the vision plan managed by the Health Care and Benefits Division within the Montana Department of Administration and subject to the oversight of the State of Montana Legislative Audit Division (the State). You can review the detail that supports CTI's findings and recommendations in our ***Specific Findings Report***.

CTI specializes in the audit and control of health plan claim administration. Accordingly, the statements we make relate narrowly and specifically to the overall effectiveness of policies, procedures, and systems VSP used to pay the State's claims during the audit period.

CTI conducted the audit according to accepted standards and procedures for claim audits in the health insurance industry. We based our audit findings on the data and documentation provided by the State and VSP. The validity of our findings relies on the accuracy and completeness of that information. We planned and performed the audit to gain reasonable assurance claims were adjudicated consistently and accurately in relationship to the policy provisions and administrative agreement between the State and VSP. As required by the State, a draft of this report was also reviewed by certified public accountant, Nick George, of Brown & Brown Insurance. While he did not review source documentation, no exceptions to our findings were noted.

While performing the audit, CTI complied with all confidentiality, non-disclosure, and conflict of interest requirements and did not receive anything of value or any benefit of any kind other than agreed upon audit fees.

OBJECTIVES AND SCOPE

The objectives of CTI's audit of VSP's claim administration were to determine whether:

- VSP followed the terms of its contract with the State;
- VSP paid claims according to the provisions of the plan documents and if those provisions were clear and consistent;
- members were eligible and covered by the State's plan at the time a service paid by VSP was incurred; and
- any claim administration systems or processes need improvement.

CTI audited VSP's claim administration of the State's vision plan for the period of January 1, 2023 through December 31, 2023. The population of claims and amount paid during that period were:

Total Paid Amount	$1,172,400
Total Number of Claims Paid/Denied/Adjusted	13,314

The audit included the following components which are described in greater detail on the following pages:

- Random Sample Audit of 110 Claims
- Operational Review and Questionnaire

AUDIT FINDINGS AND RECOMMENDATIONS

Random Sample Findings

CTI validated claim processing accuracy based on a sample of 110 vision claims paid or denied by VSP during the audit period. We selected the random sample to provide a statistical confidence level of 95% +/- 3% margin of error.

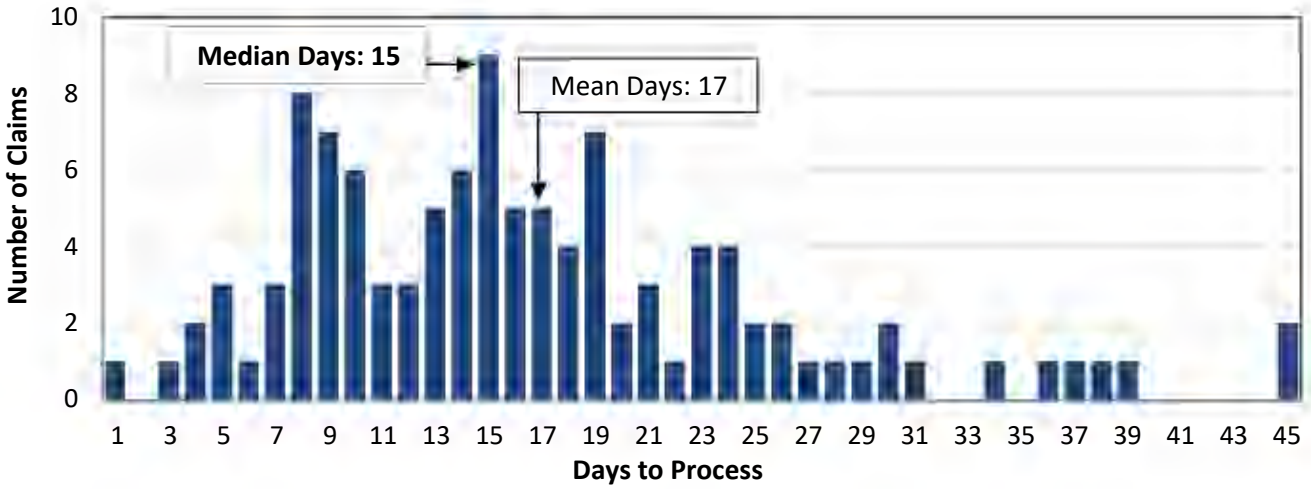
CTI's audit revealed only one error to which VSP agreed, resulting in a $62.40 overpayment. The error was categorized into the following three key performance indicators.

	Key Performance Indicators	Performance
1	**Financial Accuracy:** Compares total dollars associated with correct claim payments to total dollars of correct claim payments that should have been made.	**99.88%**
2	**Accurate Payment:** Compares number of correctly paid claims to total number of claims paid.	**99.09%**
3	**Accurate Processing:** Compares number of claims processed without any type of error (financial or non-financial) to total number of claims processed.	**99.09%**

Claim Turnaround Time

A final measure of claim administration performance is claim turnaround time. Through the audit sample, VSP demonstrated its median turnaround time on a complete claim submission was 15 days from the date it received a complete claim to the date the claim was paid or denied.

Median and Mean Claim Turnaround



Random Sample Recommendation

VSP agreed in its response to the draft report that the one error cited was due to a VSP processing error. Rather than seek refund, VSP indicated it will directly credit the State as requesting a refund would negatively impact the member.

CTI recommends the State continue to perform periodic due diligence follow-up audits to ensure VSP continues to perform above benchmark, and no new processing issues occur.

Operational Review Findings

VSP completed our Operational Review Questionnaire and provided information on its:

- Systems, staffing, and workflow;
- Claim administration and eligibility maintenance procedures; and
- Internal control risk mechanisms, e.g., HIPAA protections; internal audit policies and practices; and fraud, waste, and abuse detection and prevention.

Our Operational Review indicated:

- VSP had performance guarantees in place with the State for the following globally reported measures based on their entire book of business: claims processing, call center management, satisfaction, and account administration. VSP also had one client-specific standard in place for its Account Team Report Card.

  Based on the self-reported results provided to CTI, most but not all guarantees were met during the audit period. Specifically:

  - First Quarter – All self-reported guarantees showed as met.
  - Second Quarter – Missed one guarantee for claims processing. The missed guarantee stated that 95% of all member claims be processed within five business days. According to VSPs self-reported results, only 79.3% of claims were processed within five business days.
  - Third Quarter – Missed two guarantees for claims processing. The first guarantee stated that 95% of all member claims be processed within five business days. The second guarantee missed stated that 99% of all member claims be processed within 15 business days. According to VSPs self-reported results, only 86.2% of claims were processed within five business days and 98.2% processed within 15 business days.

    VSP also indicated it missed its guarantee for online reports to be posted to VSP's Resource Center by the 25th of the month in the third quarter.
  - Fourth Quarter – All self-reported guarantees showed as met.

  VSP confirmed in a February 27, 2024 communication to the State titled *VSP Performance Guarantee Penalty Payout* that a total of four guarantees were missed during the audit period with a total penalty owed of $275.85. An ACH payment for that amount was made by VSP on March 12, 2024 and received by the State on March 14, 2024.
- Departments with critical business processes that had an impact on VSP within the first seven days of an incident had a business continuity plan. The plan addressed all requirements as mandated by HIPAA and included backups where each critical system and application was replicated every five minutes to an external site in Philadelphia, PA.
- VSP had adequately documented training, workflow, procedures, and systems.
- When a member had other insurance, payment was limited to the plan allowance or the member's out-of-pocket (OOP) amount, whichever was less. Although requested, VSP did not provide a report showing coordination of benefits savings.
- VSP had a $50.00 minimum threshold to pursue overpayments and auto recouped overpayments from current payments. VSP did not maintain an overpayment tracking report. For self-funded

clients, VSP's Product and Payment Integration management worked with internal business partners in the appropriate Strategic Business Unit (SBU) to address any restitution required.

- VSP provided a copy of its procedures for handling member appeals. VSP's policy indicated appeals must be acknowledged within five days and the initial determination completed within 30 days. VSP stated there were no member appeals filed during the audit period.
- VSP had a dedicated special investigation unit (SIU) to investigate fraud, waste, and abuse. The unit was staffed with a CEO, Vice President of Internal Audit, SIU Manager, and SIU Fraud Investigators. When abusive billing was identified, VSP terminated the provider from its network. VSP also stated it verified providers against external sanction and preclusion sources.
- CTI screened 100% of claims against incurred during the audit period to the Office of Inspector General's List of Excluded Individuals and Entities (OIG's LEIE) and there were no claims paid to providers on the OIG's LEIE listing.
- VSP had a policy to reimburse members without provider access within 25 miles of their home zip code – or if an appointment was not available within 30 days with an in-network provider. The State was aware of this procedure.
- CTI was unable to calculate and independently validate provider discounts for the State because VSP did not provide the requested data in electronic format.
- VSP reported 95.93% of claims came from in-network providers.
- VSP stated it conducted annual HIPAA security training online and reported no breaches for the State's members during the audit period.

Operational Review Recommendations

CTI recommends the State consider asking VSP to provide sufficient detail in the claim file it provides to the vision claim auditor to allow for independent validation of VSP's self-reported provider discounts.

CONCLUSION

We understand you will need to review these findings and recommendations to determine your priorities for action. Should the State desire additional assistance with this, our contract offers eight hours of post-audit time to help you create an implementation plan.

CTI also suggests that the State perform a follow-up audit to ensure VSP continues to perform above benchmark, and that no new processing issues occur.

We consider it a privilege to have worked with the State and your staff. We welcome any opportunity to assist you in the future. Thank you again for choosing CTI.

CLAIM TECHNOLOGIES INCORPORATED

PART OF THE BROWN & BROWN TEAM

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Comprehensive Claim Administration Audit

SPECIFIC FINDINGS REPORT

State of Montana Vision Plan

Administered by VSP Vision Care

Audit Period: January 1, 2023 through December 31, 2023

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INTRODUCTION

This ***Specific Findings Report*** contains CTI's findings and recommendations from our audit of VSP Vision Care's (VSP) administration of the vision plan managed by the Health Care and Benefits Division within the Montana Department of Administration and subject to the oversight of the State of Montana Legislative Audit Division (the State). The statistics, observations, and findings in this report constitute the basis for the analysis and recommendations presented under separate cover in the ***Executive Summary***. We provide this report to the State, the plan sponsor, and VSP, the claims administrator. A copy of VSP's response to these findings can be found in Appendix B of this report.

CTI specializes in the audit and control of health plan claim administration. Accordingly, the statements we make relate narrowly and specifically to the overall effectiveness of policies, procedures, and systems VSP used to pay the State's claims during the audit period.

CTI conducted the audit according to accepted standards and procedures for claim audits in the health insurance industry. We based our audit findings on the data and documentation provided by the State and VSP. The validity of our findings relies on the accuracy and completeness of that information. We planned and performed the audit to gain reasonable assurance claims were adjudicated consistently and accurately in relationship to the policy provisions and administrative agreement between the State and VSP. As required by the State, a draft of this report was also reviewed by certified public accountant, Nick George, of Brown & Brown Insurance. While he did not review source documentation, no exceptions to our findings were noted.

While performing the audit, CTI complied with all confidentiality, non-disclosure, and conflict of interest requirements and did not receive anything of value or any benefit of any kind other than agreed upon audit fees.

Audit Objectives

The objectives of CTI's audit of VSP's claim administration were to determine whether:

- VSP followed the terms of its contract with the State;
- VSP paid claims according to the provisions of the plan documents and if those provisions were clear and consistent;
- members were eligible and covered by the State's plan at the time a service paid by VSP was incurred; and
- any claim administration systems or processes need improvement.

Audit Scope

CTI audited VSP's claim administration of the State's vision plan for the period of January 1, 2023 through December 31, 2023. The population of claims and amount paid during that period were:

Total Paid Amount	$1,172,400
Total Number of Claims Paid/Denied/Adjusted	13,314

The audit included the following components:

1. **Operational Review**
   - Claim administrator information
   - Claim administrator claim fund account
   - Claim adjudication and eligibility maintenance procedures
   - HIPAA compliance

2. **Random Sample Audit of 110 Claims**
   - Statistical confidence at 95% +/- 3%
   - Key Indicator performance levels
   - Identify and prioritize problems

OPERATIONAL REVIEW

Objective

CTI's Operational Review evaluates VSP's claim administration systems, staffing, and procedures to identify any deficiencies that materially affect its ability to control risk and pay claims accurately on behalf of the plan.

Scope

The scope of the Operational Review included:

- Claim administrator information
  - Insurance and bonding
  - Conflicts of interest
  - Financial reporting
  - Business continuity planning
  - Performance Standards
  - Claim payment system and coding protocols
  - Data and system security
- Claim funding
  - Claim funding mechanism
  - Check processing and security
- Claim adjudication, customer service, and eligibility maintenance procedures
  - Exception claim processing
  - Eligibility maintenance and investigation
  - Other insurance coverage and adjudication
  - Overpayment recovery
  - Network utilization
  - Fraud waste and abuse
  - Appeals processing
- HIPAA compliance

Methodology

CTI used an Operational Review Questionnaire to gather information from VSP. We modeled our questionnaire after the audit tool used by certified public accounting firms when conducting a Systems and Organization Controls (SOC) audit of a service administrator. We modified that tool to elicit information specific to the administration of your plan.

We reviewed VSP's responses and any supporting documentation supplied to gain an understanding of the procedures, staffing, and systems used to administer the State's plan. This allowed us to conduct the audit more effectively.

Findings

We observed the following:

- VSP indicated it maintained levels and types of insurance reasonable and customary for a health services organization with comparable size and market presence. In addition, the levels of coverage complied with the State's requirements.
- VSP provided a copy of its System and Organization Controls (SOC) 2 Type 2 Report on the Care Claims Processing System and on the Suitability of the Design and Operating Effectiveness of Controls Relevant to Security and Processing Integrity (the Report) for the period of January 1, 2023 through December 31, 2023 issued by its external auditor BDO USA. The report was issued in accordance with the requirements of the American Institute of Certified Public Accountants (AICPA). BDO performed various testing procedures against the internal controls identified by VSP in the following areas:
    - Control Environment
    - Communication and Information
    - Risk Assessment
    - Monitoring Activities
    - Control Activities
    - Logical and Physical Access Controls
    - System Operations
    - Change Management
    - Risk Mitigation
- VSP had performance guarantees in place with the State for the following globally reported measures based on their entire book of business: claims processing, call center management, satisfaction, and account administration. VSP also had one client-specific standard in place for its Account Team Report Card.

  Based on the self-reported results provided to CTI, most but not all guarantees were met during the audit period. Specifically:

    - First Quarter – All self-reported guarantees showed as met.
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      VSP also indicated it missed the guarantee that online reports be posted to VSP's Resource Center by the 25th of the month in the third quarter.
    - Fourth Quarter – All self-reported guarantees showed as met.

  VSP confirmed in a February 27, 2024 communication to the State titled *VSP Performance Guarantee Penalty Payout* that a total of four guarantees were missed during the audit period with a total penalty owed of $275.85. An ACH payment for that amount was made by VSP on March 12, 2024 and received by the State on March 14, 2024.

- VSP has used the Proclaim claim processing system since 1992. System access was role based. VSP used concepts such as least privilege, need to know, and minimum necessary when granting system access.
- Departments with critical business processes that had an impact on VSP within the first seven days of an incident had a business continuity plan. The plan addressed all requirements as mandated by HIPAA and included backups where each critical system and application was replicated every five minutes to an external site in Philadelphia, PA.
- VSP reported it used Language Line Solutions based in Portland, OR and Monterey, CA for translation services. According to VSP, it did not inform the State of this vendor. VSP indicated it did maintain performance guarantees for this vendor during the audit period.
- VSP had adequately documented training, workflow, procedures, and systems.
- When a member had other insurance, payment was limited to the plan allowance or the member's out-of-pocket (OOP) amount, whichever was less. Although requested, VSP did not provide a report showing coordination of benefits savings.
- VSP indicated it received 90% of claims electronically and auto adjudicated 89% of claims.
- VSP had a $50.00 minimum threshold to pursue overpayments and auto recouped overpayments from current payments. VSP did not maintain an overpayment tracking report. For self-funded clients, VSP's Product and Payment Integration management worked with internal business partners in the appropriate Strategic Business Unit (SBU) to address any restitution required.
- VSP provided a copy of its procedures for handling member appeals. VSP's policy indicated appeals must be acknowledged within five days and the initial determination completed within 30 days. VSP stated there were no member appeals filed during the audit period.
- VSP had a dedicated special investigation unit (SIU) to investigate fraud, waste, and abuse. The unit was staffed with a CEO, Vice President of Internal Audit, SIU Manager, and SIU Fraud Investigators. When abusive billing was identified, VSP terminated the provider from its network. VSP also stated it verified providers against external sanction and preclusion sources.
- CTI screened 100% of claims against incurred during the audit period to the Office of Inspector General's List of Excluded Individuals and Entities (OIG's LEIE) and there were no claims paid to providers on the OIG's LEIE listing.
- VSP had a policy to reimburse members without provider access within 25 miles of their home zip code – or if an appointment was not available within 30 days with an in-network provider. The State was aware of this procedure.
- CTI was unable to calculate and independently validate provider discounts for the State because VSP did not provide the requested data in electronic format.
- VSP reported 95.93% of claims came from in-network providers.
- VSP stated it conducted annual HIPAA security training online and reported no breaches for the State's members during the audit period.

RANDOM SAMPLE AUDIT

Objectives

The objectives of our Random Sample Audit were to determine if claims were paid according to plan specifications and the administrative agreement and to prioritize areas of administrative deficiency for further review and remediation.

Scope

CTI's Random Sample Audit included a stratified random sample of 110 paid or denied claims. The statistical confidence level of the audit sample was 95%, with a 3% margin of error. A copy of the Sample Construction and Weighting Methodology Report for the sample is in Appendix A.

VSP's performance was measured using the following key performance indicators:

- Financial Accuracy
- Accurate Payment
- Accurate Processing

We also measured claim turnaround time, a commonly relied upon performance measure.

Methodology

Our Random Sample Audit ensures a high degree of consistency and is based upon the principles of statistical process control with a management philosophy of continuous quality improvement. Our auditors reviewed each sample claim selected to ensure it conformed to plan specifications, agreements, and negotiated discounts. We recorded our findings in our proprietary audit system.

When applicable, we cited claim payment and processing errors identified by comparing the way a selected claim was paid and the information VSP had available at the time the transaction was processed**. It is important to note that even if the sampled claim was subsequently corrected prior to CTI's audit, we have still cited the error so you can discuss how to reduce errors and re-work in the future with your administrator.**

CTI communicated with VSP in writing via system-generated response forms regarding any errors or observations. We sent VSP a preliminary report for its review and written response. We considered VSP's written response, as found in Appendix B, when producing our final reports.

Findings

Financial Accuracy

CTI defines Financial Accuracy as the total correct claim payments made compared to the total dollars of correct claim payments that should have been made for the audit sample.

The claims sampled and reviewed revealed no underpayments and $62.40 in overpayments, for a combined variance of $62.40. Had all claims in the sample been paid correctly, the total paid amount for the sampled claims would have been $51,720.38.

The weighted Financial Accuracy rate was 99.88%.

Accurate Payment Frequency
CTI defines Accurate Payment Frequency as the number of claims paid correctly compared to the total number of claims paid for the audit sample.

The audit sample revealed 1 incorrectly paid claim and 109 correctly paid claims. Note CTI only uses adequately documented claims for this calculation.

Total Claims	Incorrectly Paid Claims		Frequency
	Underpaid	Overpaid	
110	0	1	99.09%

Accurate Processing Frequency
CTI defines Accurate Processing Frequency as the number of claims processed without errors compared to the total number of claims processed in the audit sample. When a claim had errors that applied in more than one category, it was counted only once as a single incorrect claim for this measure.

Correctly Processed Claims	Incorrectly Processed Claims		Frequency
	System	Manual	
109	0	1	99.09%

Random Sample Findings Detail Report				
Audit No.	Under/ Over Paid	VSP Response	CTI Conclusion	Manual or System
Usual and Customary – Disallowed Calculation Error				
1052	$62.40	Agree. On the original claim [redacted], we overpaid on claim [redacted]. Total paid between the two was $610.00 and we should have paid $547.60 = $62.40 overpayment. Since this a VSP processing error, we will not be requesting a refund from the member. However, VSP will ensure State of Montana is credited $62.40.	Procedural deficiency and overpayment remain. Total paid was $610.00 and it should have been $547.60.	☒ M ☐ S

Claim Turnaround
CTI defines Claim Turnaround as the number of calendar days required to process a claim – from the date the claim was received by the administrator to the date a payment, denial, or additional information request was processed – expressed as both the Median and Mean for the audit sample.

Claim administrators commonly measure claim turnaround time in mean days. Median days, however, is a more meaningful measure for administrators to focus on when analyzing claim turnaround because it prevents one or just a few claims with extended turnaround time from distorting the true performance picture.

Median	Mean	+45 Days to Process
15	17	2

CONCLUSION

We consider it a privilege to have worked for, and with, your staff and administrator. Our contract offers eight hours of post-audit time to help you develop an implementation plan should the State desire additional assistance in that regard.

Thank you again for choosing CTI.

APPENDIX A – SAMPLE CONSTRUCTION AND WEIGHTING METHODOLOGY

Client: MTVSP23
Audit Period: January 01, 2023 - December 31, 2023

Claim Universe (as converted)

Stratum		Claim Count	Total Charge Amount	Total Paid Amount
<=500	1	13,242	$4,233,573	$1,122,091
<=10,000	2	33	$14,942	$11,134
>10,000	3	39	$40,147	$39,175
	Totals	13,314	$4,288,661	$1,172,400

Audit Stratification

Stratum		Audit Universe (# Claims)	Proportion (Weight by Count)	Sample
<=500	1	13,242	99.46%	73
<=10,000	2	33	0.25%	37
>10,000	3	39	0.29%	0
	Totals	13,314	100.00%	110

Audit Sample Overview

Category	Count	Paid Amount
Claims requested for audit	110	$51,782.78
Claims for which records not received	0	$0.00
Claims outside scope of audit	0	$0.00
Claims as entered included in audit sample	110	$51,782.78
Audit sample if all claims paid correctly	110	$51,720.38
Claims with inadequate documentation	0	$0.00
Total claim payments remaining in audit sample	110	$51,720.38

APPENDIX B – ADMINISTRATOR RESPONSE TO DRAFT REPORT

Please note that any additional information submitted to CTI in response to the draft report from the administrator is reviewed, and observations may be removed prior to the final report being published. While a removed observation will not be included in the final report, it may be referenced in the administrator's response that follows.

vsp vision care

April 18, 2024

Claim Technologies Incorporated
Attn: Deb Danilson, Account Executive
100 Court Avenue, Suite 306
Des Moines, IA 50309

RE: State of Montana Draft Specific Findings VSP_041824 – Response

Hello Deb,

Thank you for submitting the most recent Draft Specific Findings regarding the State of Montana audit. Below are VSP's responses. Please let us know if anything further is needed from VSP.

Cordially,

Cathy Rapozo, Sr. Account Manger

cc: Valerie Swyers, Christine Dahdouh

Random Sample Findings Detail Report				
PPO Discount Amount				
Usual and Customary – Disallowed Calculation Error				
1052	[redacted]	Agree. On the original claim [redacted], we overpaid on claim [redacted]. Total paid between the two was [redacted] and we should have paid [redacted] overpayment. Since this a VSP processing error, we will not be requesting a refund from the member. However, VSP will ensure State of Montana is credited [redacted] VSP Response 04/18/2024: VSP agrees with this procedural deficiency.	Procedural deficiency and overpayment remain. Total paid was [redacted] and it should have been [redacted]	☒ M ☐ S

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